Program Evaluation of World Hope International's Trafficking in Persons – Recovery Centre in Sierra Leone

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Program Evaluation of World Hope International's Trafficking in Persons - Recovery Centre in Sierra Leone

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ACRONYMS & ABBREVIATIONS

AWC	Aberdeen Women's Centre
CBO	Community-Based Organization
CCAT	Clinical Care Assessment Tool
FAAST	Faith Alliance Against Slavery and Trafficking
FGM	Female Genital Mutilation
FSU	Family Support Unit (in Sierra Leone Police)
GBV	Gender-Based Violence
GOSL	Government of Sierra Leone
IOM	International Organization for Migration
J/TIP	U.S. Department of State's Office to Monitor and Combat Trafficking in Persons
MOU	Memorandum of Understanding
MSWGCA	Ministry of Social Welfare, Gender, and Children's Affairs
NGO	Non-Governmental Organization
PRAT	Post-Reintegration Assessment Tool
PTSD	Posttraumatic Stress Disorder
SL	Sierra Leone
SLP	Sierra Leone Police
TCPS	Trauma Care and Protection Specialist
TF-CBT	Trauma-Focused Cognitive Behavior Therapy
TIP	Trafficking in Persons
TIP-RC	Trafficking in Persons – Recovery Centre
TOCU	Transnational Organized Crime Unit (in Sierra Leone Police)
TVPA	Trafficking Victims Protection Act
UNICEF	United Nations Children's Fund
VPG	Village Parent Group (WHI TIP Prevention Program)
WMF	Word Made Flesh
WHI	World Hope International
VoT	Victim of Trafficking

EXECUTIVE SUMMARY

This is a report of an external program evaluation of the Trafficking in Persons – Recovery Centre (TIP-RC) funded by the United States Department of State's Office to Monitor and Combat Trafficking in Persons (J/TIP). The project was implemented in Sierra Leone by World Hope International (WHI). The project began in 2012, but its implementation was limited for nearly a year during the Ebola epidemic in West Africa, starting in August 2014. The project temporarily closed in July 2015 due to a lapse in funding, but it was re-initiated in October 2015. This evaluation will primarily focus on the period since October 2015.

The on-site evaluation was conducted in June 2016 by a licensed psychologist who completed an earlier evaluation of the TIP-RC Project in 2013. The core objectives of the evaluation were: (a) to assess implementation outputs not addressed in the original evaluation, and (b) to measure the expected outcomes of this project. The goals of this evaluation project are: (a) to provide recommendations to WHI to improve their model of services, and (b) to provide recommendations to J/TIP to inform their decisions regarding the future design, implementation, and funding of comprehensive aftercare programs for child victims of human trafficking. This report includes the consolidated findings from the desk review and the fieldwork in Sierra Leone as well as the evaluator's conclusions, recommendations, and lessons learned.

RESEARCH METHOLOGY

The main questions addressed by the evaluation include:

1. How does cooperation with partner organizations contribute to this model of services?
2. How do referral and screening procedures used to identify and admit beneficiaries to the TIP-RC contribute to or undermine implementation of this program model?
3. How do reintegration services contribute to or undermine implementation of this program model?
4. How effective has WHI been in building staff capacity at the TIP-RC?
5. How effective has the TIP-RC been in achieving stabilization and recovery of survivors?
6. How effective has the TIP-RC been in achieving successful reintegration of survivors in the Sierra Leone community?

To answer the evaluation questions, a broad range of qualitative and quantitative data was collected to inform the evaluation's conclusions, recommendations, and lessons learned. The evaluation methodology was compromised of five main components:

1. **A literature review on human trafficking and other related issues.** The human trafficking literature was reviewed, with a special focus placed on the aftercare service delivery literature and child trafficking literature. As a means to supplement the limited literature on reintegration outcomes for victims of trafficking (VoT), the literature on reintegrated former child soldiers in Sierra Leone was also reviewed.
2. **A desk review of documentation.** A desk review was comleted of the following documentation: (a) grant documents and progress reports; (b) all TIP-RC policy, procedures, and forms; and (c) training materials and curriculum.

3. **Semi-structured interviews.** WHI employees and key informants at partner organizations were interviewed using an interview guide, which was developed to obtain primary data regarding the evaluation questions.
4. **Direct observations.** The evaluator completed direct observations of the TIP-RC staff members engaged in their normal job responsibilities, including six different shelter activities, one social worker follow-up training, and three regularly scheduled TIP-RC staff meetings.
5. **Case file analyses.** Primary data was obtained from WHI's Data Sheet and case registration forms in the case files. Also, a chart review was conducted on 8 randomly chosen case files using a chart review rubric. Additional archival data used in this evaluation included the following client assessment data found in the case files: (a) the Clinical Care Assessment Tool (CCAT), which is supposed to be administered three times to all clients while in the shelter (i.e., baseline, midpoint, and endpoint administrations); and (b) the Post-Reintegration Assessment Tool (PRAT), which is supposed to be administered to all reintegrated clients 9-months after reintegration.

This evaluation used a non-experimental design to evaluate this project. As a result, definitive causal relationships cannot be established between program inputs, outputs, and outcomes. All findings about what factors contribute to project outcomes must be considered as suggestive, rather than conclusive.

BACKGROUND ON THE TIP-RC PROJECT

According to the 2016 Trafficking in Persons Report (U.S. Department of State, 2016), Sierra Leone is a source and destination country for trafficking in persons (TIP). Men, women, and children are most commonly trafficked from rural areas to urban areas for the purpose of exploitation in forced labor, domestic servitude, prostitution, and forced marriages. WHI has implemented anti-trafficking efforts in Sierra Leone since 2004, with intial projects focused on TIP prevention as well as the provision of case management services for identified victims. The TIP-RC Project developed in response to the increased identification of VoT as a result of their prevention programs. Yet, WHI was unable to adequately protect and assist these victims due to the lack of comprehensive aftercare services for VoT in Sierra Leone.

WHI initiated the TIP-RC Project in Freetown, Sierra Leone in March 2012, using funding from J/TIP. The TIP-RC provides holistic and comprehensive aftercare services to primarily female child trafficking victims by providing: (a) safe residential care for approximately 6 months; (b) short-term clinical care that addresses victims' physical health, mental health, and social needs; (c) legal support; and (d) reintegration support and case management services. The ultimate goal of these services is to support the recovery and successful reintegration of VoT into the Sierra Leone community. The TIP-RC also provides outreach trainings and advocacy on human trafficking issues with the intended pupose of strengthening sustainable systems and infrastructure that combat TIP in Sierra Leone.

At the time of the field research, 117 residential clients (63 during the pre-Ebola period, 21 during the Ebola period, and 37 since the shelter re-opened in October 2015) have received comprehensive aftercare services at the TIP-RC. In addition, 37 non-residential clients have

received case management services. Since the TIP-RC reopened, 93% of the residential clients have been VoT, whereas 7% have been suspected TIP cases that turned out not to involve trafficking. Currently, the average length of residential care before reintegration is a little over 3 months, while reintegrated clients are provided reintegration support services for approximately 12 months after reintegration.

KEY FINDINGS

It can be concluded that TIP-RC Project has obtained successful results in a challenging environment. There is substantial evidence that the TIP-RC provides high quality, comprehensive aftercare services for primarily young female VoT in Sierra Leone. Moreover, the TIP-RC program model is generally effective in supporting the recovery of predominantly child trafficking victims and then successfully reintegrating them into normal community life in a low resourced country. However, one of the major weaknesses of the TIP-RC Project is that it lacks a sustainability plan in regards to funding. Two major issues negatively impact the sustainability of the TIP-RC Project: (a) the high cost of providing quality comprehensive care, and (b) the lack of funding from the government of Sierra Leone (GOSL). Still, the findings provide considerable support for the TIP-RC to be considered a best practice model for child trafficking victim assistance programs in West Africa. Other findings will be discussed below.

Cooperation with Partner Organizations. Developing collaborative partnerships with a wide range of organizations is one of the key factors in the project's ability to provide high quality comprehensive aftercare services in Sierra Leone, while controlling costs. Cooperation with partner organizations contributes to the TIP-RC program model in several ways, including: (a) receiving official recognition from the GOSL; (b) improving victim identification and the use of referrals mechanisms to obtain psychosocial care for identified victims; (c) providing free or discounted medical care to adequately address clients' physical health problems; (d) offering residential care through alternative care providers for referred cases that do not meet the TIP-RC's residential admission criteria and for clients who cannot be reintegrated with family members; (e) supplementing their reintegration support services with assistance from implementing partners (e.g., helping with family tracing and monitoring reintegrated cases); and (f) offering some assistance with their clients' immigration and legal issues. Yet, WHI needs to develop stronger partnerships with legal service providers and other human rights groups in Sierra Leone to promote increased prosecutions and convictions of trafficking-related offenses.

Referral and Screening Procedures. These procedures are in compliance with best practices from the victim identification literature (IOM, 2007; Macy & Graham, 2012). The project's TIP-related trainings, in addition to WHI's strong focus on relationship building with partner organizations, have improved the ability of the GOSL and other organizations to accurately identify and refer VoT to the shelter. Also, these efforts have helped the GOSL to strengthen the national referral mechanism, increasing the likelihood that child trafficking victims in Sierra Leone are being systematically identified, protected, and supported in their recovery process.

Reintegration Support Services. The reintegration support services provided by the TIP-RC generally comply with recommended practices in the aftercare service delivery literature (IOM, 2007; Muraya & Fry, 2016). These services generally strengthen the TIP-RC program model and

contribute to successful reintegration outcomes. However, the weaknesses in their current service delivery model generally involve not providing sufficient levels of some of these services, as recommended in the aftercare service delivery literature (IOM, 2007; Muraya & Fry, 2016). These include: (a) not providing enough family bonding visits; (b) not adequately resourcing or supporting families to make their income generating projects sustainable; and (c) conducting fewer community-based follow-up visits for reintegrated clients than recommended. These weaknesses are primarily due to funding limitations. This compromised practice has not generally interfered with the TIP-RC's ability to obtain positive reintegration outcomes, except for the outcomes related to the income generating projects.

Staff Capacity Outcomes. At the outset of the TIP-RC Project, WHI struggled with recruiting and hiring qualified staff members because Sierra Leone has few professionally trained and qualified human service providers. WHI addressed this implementation issue by: (a) hiring Sierra Leonean staff members with the appropriate soft qualities to be competent caregivers; (b) employing an expatriate staff member with the appropriate clinical credentials to fill a clinical supervisor role; and (c) providing on-going training and clinical supervision to all staff members throughout the course of the project. The evaluation findings indicate that WHI has developed the professional capacity of the TIP-RC staff members to generally competent levels in several domains, including: (a) providing trauma-informed care; (b) developing and implementing appropriate treatment plans and reintegration plans; (c) engaging in several aspects of data-based decision making; and (d) managing job-related stress via organizational support and some use of self-care practices. Further development needs to occur in: (a) utilizing trauma-informed care practices to manage externalizing problems (e.g., physical and verbal aggression) in residential clients; (b) using data to monitor intervention effectiveness at both an individual and a programmatic level; and (c) maintaining clinical documentation according to WHI policy. Because the provision of quality care is linked to employing highly-skilled service providers, it is doubtful that the TIP-RC Project would have made significant progress in reaching program goals without investing the resources to build the professional capacity of the TIP-RC staff.

Stabilization and Recovery Outcomes. Based on the evidence available, the TIP-RC Project has generally been effective in stabilizing and recovering VoT over a broad range of comorbid problems during the course of residential care. The comprehensive aftercare services have had beneficial effects on significantly improving the following areas for the clientele: (a) physical health problems, (b) some mental health symptoms (i.e., trauma-related symptoms and internalizing problems), (c) coping skills, (d) self-confidence, (e) self-protection skills, and (f) academic and/or vocational functioning while in the shelter. No improvements were identified in the clients' ability to utilize spiritual resources as a means to cope with stressors, but this seems to be an area of strength for the majority of the clients when they enter the shelter. Additionally, the TIP-RC clients generally reported only small, yet non-significant improvements in mental health symptoms related to externalizing problems (i.e., hostility) and prosocial behaviors. Because there is substantial comorbidity between these two problems, WHI should focus on improving staff members' ability to manage aggression and to utilize evidence-based interventions for externalizing problems. Still, it is likely that the improvements seen in the residential clients, over a wide range of psychosocial domains, during the course of residential care is due to their provision of comprehensive services.

Reintegration Outcomes. Based on the evidence available, the TIP-RC Project has been somewhat effective in successfully reintegrating VoT in the Sierra Leone community, even though these results are mixed. The TIP-RC reported only losing contact with approximately 3% of their reintegrated clients (before discharge from the program) over the course of the entire project, which suggests that probably few reintegrated clients have been re-trafficked during the standard 12-month follow-up period after reintegration. The majority of the TIP-RC clients demonstrated good reintegration outcomes (i.e., low rates of mental symptoms and few problems related to psychosocial functioning) approximately 8 months after reintegration into normal Sierra Leone community life for the following areas: (a) exploitation risk factors related to physical health and community risk factors; (b) family acceptance and support; (c) community acceptance; and (d) psychosocial adjustment related to externalizing symptoms, prosocial behaviors, self-confidence, spiritual resources, and coping skills. Yet, moderate to high rates of family risk factors were identified for 25% of the reintegrated clients, whereas 39% of the reintegrated clients showed moderate to high rates of poor educational or vocational functioning after being reintegrated for approximately 8 months. Moreover, between 24%-35% of all reintegrated clients demonstrated moderate to high rates of trauma-related symptoms, internalizing problems (i.e., depression and anxiety), and problematic self-protection skills. In comparison to residential care, reintegrated clients also experienced more psychological distress and poorer psychosocial functioning in these areas after living in normal Sierra Leone community life for approximately 8 months. Some of the poor reintegration outcomes for family risk factors, educational functioning (due to being unable to pay for school fees), and psychosocial adjustment could be related to the high rates of economic insecurity in the post-reintegration families; thus, improving their reintegration support packages, especially the income generating projects, could have the biggest impact on further improving the project's reintegration outcomes.

RECOMMENDATIONS

This evaluation's overarching recommendation is to continue the TIP-RC Project due to its successful results in a challenging environment. The following recommendations are offered to WHI to improve the model of services at the TIP-RC:

Develop a Sustainability Plan. It is recommended that WHI develop a plan to obtain sustainable funding for the TIP-RC Project.

Improve Record Keeping. The TIP-RC staff members need to improve their ability to document all clinical services in a timely fashion. It is recommended that all documentation policies and practices be updated and streamlined, and then WHI should use regular chart audits to hold staff members accountable for these policies.

Strengthen Data-Based Decision Making Practices. TIP-RC's operating procedures should be modified to improve their ability to use data to monitor the effectiveness of interventions at both an individual and a programmatic level.

Build Additional Staff Capacity. The TIP-RC staff members need to be trained and supervised on using evidence-based interventions to reduce externalizing problems in the clientele.

Develop Additional Collaborative Partnerships. WHI needs to prioritize the development of collaborative partnerships with local organizations that provide the following services: (a) legal aid services; (b) vocational training; (c) community-based support services for children; and (d) micro-finance and business support for the income generating projects.

Improve Vocational Training. WHI should employ a Vocational Coordinator who can teach a marketable vocational skill for the Sierra Leone context and provide training on general business skills.

Strengthen Reintegration Support Packages. WHI should increase the size of the income generating projects, for at least the most economically insecure families, and provide additional training to the TIP-RC Social Workers on how to develop and support effective income generating projects for these families.

Continue Advocating and Training on TIP Issues. WHI should continue advocating and training on TIP-related issues to the GOSL and partner organizations to further improve accurate victim identification and the consistent use of the TIP national referral mechanism.

LESSONS LEARNED

The following lessons learned and promising practices have been identified to inform J/TIP's decisions regarding the future design, implementation, and funding of comprehensive aftercare services for child trafficking victims:

Program Design. More effective outcomes are likely to be obtained when program designs include the following:

1. Strong referral services, including outreach trainings and advocacy for TIP-related issues;
2. Comprehensive service provision aimed at stabilizing and recovering clients, including residential care, physical health care, mental health care, chemical dependency treatment, education, vocational training, life skills education, and legal support;
3. Comprehensive reintegration support services, including (a) assessing and preparing clients, families, and communities for reintegration; (b) identifying reintegration protective factors and mitigating reintegration risk factors for clients, families, and communities; (c) utilizing adequate economic assistance strategies to help families obtain a sustainable income; (d) developing reintegration plans based on the best interest of clients and utilizing alternative care placements only if risk factors cannot be sufficiently reduced; and (e) implementing regular monitoring practices (e.g., phone calls and community-based follow-up visits) and providing any necessary post-reintegration interventions for at least 12 months after reintegration;
4. Appropriate staffing levels using professionally qualified service providers;
5. Systematic strategies to build staff capacity when operating in low resourced countries that have few professionally trained human service providers;
6. Effective monitoring and evaluation procedures, including evidence that staff members will routinely collect and analyze various forms of culturally and clinically relevant data

to identify problems, to inform decision making about interventions, and to monitor intervention effectiveness at both a client-level and a program-level;

7. Plans to obtain long-term sustainable program funding.

Project Implementation. Multidisciplinary and collaborative partnerships are usually necessary to provide high quality comprehensive aftercare services while controlling for program costs. Yet, it usually takes time and strong relationship building skills to establish these partnerships. Therefore, priority should be given to fund organizations that are well networked in a region or can demonstrate a proven track-record in establishing collaborative partnerships.

Funding. When programs operate in countries with limited affordable legal services, they will need additional funding to provide effective legal support for their clients in order to promote increased convictions of TIP perpetrators. Also, providing high quality comprehensive aftercare services to child trafficking victims is expensive. Until more research is conducted to determine what level of aftercare services are needed to obtain successful reintegration outcomes in this population, comprehensive services should be considered the gold standard.

1.0 INTRODUCTION & METHODOLOGY

1.1 EVALUATION PURPOSE

World Hope International (WHI), both individually and as part of the Faith Alliance Against Slavery and Trafficking (FAAST), has implemented anti-trafficking efforts in Sierra Leone since 2004 when it received a grant from the United States Department of State's Office to Monitor and Combat Trafficking in Persons (J/TIP). Their initial project was focused on trafficking in persons (TIP) prevention, including increasing community awareness of TIP, establishing Village Parent Groups (VGP) throughout the country, developing referral mechanisms, and linking various entities to combat TIP. In 2008, WHI expanded the program to include the Rapid Response Project because of the increased identification of victims of trafficking (VoT) due to their TIP Prevention Program. Rapid Response provided case management services to meet the immediate needs of identified victims, but it became clear during the course of this project that there was not adequate or appropriate residential care for VoT in Sierra Leone. In addition, the limits of this project highlighted the need for more comprehensive aftercare services in order to adequately protect and assist VoT as well as to prevent future exploitation.

Because Sierra Leone did not have any specialized residential care or comprehensive aftercare services for VoT, WHI initiated the Trafficking in Persons – Recovery Centre (TIP-RC) in Freetown, Sierra Leone in March 2012 as a pilot project, using funding from J/TIP. The TIP-RC provides holistic and comprehensive aftercare services to primarily female child trafficking victims in Sierra Leone by providing: (a) safe residential care for approximately 6 months; (b) short-term clinical care that addresses survivors' physical health, mental health, and social needs; (c) legal support; and (d) reintegration support and case management services. The ultimate goal of these services is to support the recovery and successful reintegration of VoT into the Sierra Leone community. The TIP-RC Project also provides outreach trainings and advocacy on human trafficking issues with the intended pupose of strengthening sustainable systems and infrastructure that combat TIP in Sierra Leone.

At the conclusion of the 1-year long pilot project, a third-party program evaluation was undertaken by this evaluator, which determined that the TIP-RC program model was providing quality clinical care to VoT (Barnett, 2013). This evaluation also provided the TIP-RC with the Clinical Care Assessment Tool (CCAT) and the Post-Reintegration Assessment Tool (PRAT) in order to measure outcomes of this project, which WHI implemented in their standard operating procedure in August 2014. However, the implementation of the TIP-RC Project was limited for nearly a year during the Ebola epidemic in West Africa, also starting in August 2014. The project temporarily closed in July 2015 due to a lapse in funding, but it was re-initiated in October 2015.

As an extension of the 2013 evaluation, J/TIP contracted this evaluator to conduct another third-party program evaluation of the TIP-RC Project, primarily focusing on the period since October 2015, in order: (a) to assess implementation outputs not addressed in the original evaluation, and (b) to measure the expected outcomes of this project, including data collected from the previously developed client assessment tools. The goals of this evaluation project are: (a) to provide recommendations to WHI to improve their model of services, and (b) to provide recommendations to J/TIP to inform their decisions regarding the future design,

implementation, and funding of effective comprehensive aftercare programs for survivors of human trafficking (see Annexes 1 and 2 for Statement of Work and Disclosure of Conflict of Interest).

1.2 EVALUATION QUESTIONS

This evaluation has six evaluation questions organized under two primary objectives:

a. Assess externally-focused implementation outputs of the TIP-RC program model:
    1. How does cooperation with partner organizations contribute to this model of services?
    2. How do referral and screening procedures used to identify and admit beneficiaries to the TIP-RC contribute to or undermine implementation of this program model?
    3. How do reintegration services contribute to or undermine implementation of this program model?
b. Assess expected outcomes of the TIP-RC program model:
    1. How effective has WHI been in building staff capacity at the TIP-RC?
    2. How effective has the TIP-RC been in achieving stabilization and recovery of survivors?
    3. How effective has the TIP-RC been in achieving successful reintegration of survivors in the Sierra Leone community?

1.3 EVALUATION METHODOLOGY

To answer the evaluation questions, a broad range of qualitative and quantitative data was collected to inform the evaluation's conclusions, recommendations, and lessons learned. The evaluation was compromised of five main components: (a) a literature review on human trafficking and other related issues, (b) a desk review of documentation, (c) semi-structured interviews, (d) direct observations, and (e) case file analyses. A comprehensive evaluation design matrix was developed to link the methodology and data collection procedures with the evaluation questions (see Annex 3). In-country fieldwork was conducted between June 4, 2016 and June 18, 2016.

Literature Review
An initial literature review was conducted prior to commencing the field research, with additional resources reviewed following the field research. Very little research exists on human trafficking issues related to Sierra Leone or West Africa. Therefore, the human trafficking literature from other global regions was consulted, with a special focus placed on the aftercare service delivery literature and the child trafficking literature. As a means to supplement the limited literature on reintegration outcomes for VoT, especially in the African context, the literature on reintegrated former child soldiers in Sierra Leone was also reviewed. See the reference section for a full list of resources.

Desk Review of Documentation
Information gathering also included a desk review of all the below documentation: (a) grant documents and progress reports; (b) all TIP-RC policy, procedures, and forms (e.g., child protection policy, job descriptions, case file documentation, and the TIP Assessment Tool); and

(c) training materials and curriculum (e.g., caregiver training manuel, first aid arts curriculum, and service providers training of the trainers manual). In addition, the following documents from the Government of Sierra Leone (GOSL) were reviewed: the Anti-Human Trafficking Act of 2005 and the National Referral Protocol on Gender Based Violence.

Semi-Structured Interviews

The evaluator conducted semi-structured interviews with WHI employees and key informants at partner organizations. An interview guide was developed to obtain primary data regarding the research questions (see Annex 4). Although it addressed all the key research questions, it was not exhaustive and additional clarifying questions were asked. Also, only appropriate sections of the interview guide were utilized based on the respondent's job description or expertise (see Annex 5 for the Interview Guide Matix).

The following staff members of the TIP-RC were interviewed: Shelter Manager, Trauma Care & Protection Specialist (TCPS), 2 Counselors, 2 Social Workers, Nurse, Teacher, and 2 House Parents. In addition, semi-structured interviews were conducted with two additional WHI staff members in Sierra Leone: WHI Anti-Trafficking Technical Advisor and WHI TIP Prevention Director. Other participants in the semi-structured interviews included key informants at partner organizations, including the Family Support Unit (FSU) in the Sierra Leone police (SLP), Ministry of Social Welfare, Gender, and Children's Affairs (MSWGCA), Aberdeen Women's Centre (AWC), Rainbo Initiatives, Word Made Flesh (WMF), and two Village Parent Groups (VPG).

Direct Observations

Direct observations of the TIP-RC staff members engaged in their normal job responsibilities were used to triangulate information from the semi-structured interviews and the desk review of program documentation. The focus of the observations was on the general patterns of interaction and functioning of the TIP-RC staff members, not on individual employees or clients. The evaluator completed a recording sheet for each activity observed (see Annex 6), which was based off of Johnson's (2012) list of recommended professional staff behaviors for effective aftercare service delivery. The following shelter activities at the TIP-RC were observed by the evaluator: one meal, one life skills training session, one activity session, one vocational session, one educational session, and one first aid arts session. The evaluator also observed one social worker follow-up training with the FSU and three regularly scheduled TIP-RC staff meetings (i.e., management team meeting, case management team meeting, and the house parent meeting).

Case File Analyses

The evaluator obtained primary data about the demographic characteristics of all previous TIP-RC clients from WHI's Data Sheet. For clients admitted since October 2015, more detailed demographic information was obtained from the case registration forms included in the case files. Additionally, a chart review was conducted on 8 randomly chosen case files (5 reintegrated clients and 3 residential clients) to audit accurate documentation. The treatment plans and the reintegration plans in each of these case files were also evaluated according to a chart review rubric (see Annex 7). The chart review rubric was adapted from Hunley and McNamara's (2010) case study rubric, and it was partially based on the recommended practices for treatment plans and reintegration plans in the aftercare service delivery literature (see Clawson, Salomon, &

Grace, 2008; Grant & Hudlin, 2007; Macy & Johns, 2011; Muraya & Fry, 2016; Williamson, Dutch, & Clawson, 2010).

Additional archival data used in this evaluation included the following client assessment data found in the case files: (a) the CCAT, which is supposed to be administered three times to all clients while in the shelter (i.e., baseline, midpoint, and endpoint administrations); and (b) the PRAT, which is supposed to be administered to all reintegrated clients 9-months after reintegration (see Annexes 8 and 9). The CCAT and PRAT were developed specifically for the TIP-RC Project based on a literature review of the factors affecting reintegration outcomes and the qualitative data from the 2013 TIP-RC Evaluation (Barnett, 2013). They were designed not only to collect outcome data for the TIP-RC Project, but also to provide the clinical staff members with measurable data about client functioning in order to improve the development and implementation of treatment plans and reintegration plans. Thus, the format of the assessment tools was designed to be easily accessible for para-professionals to interpret (which is the typical service provider-level in a low resourced country).

Both the CCAT and PRAT record self-reported data from clients and clinical observations from Counselors/Social Workers; therefore, there is a client version and clinician version for each instrument. Due to the low rates of adequate literacy in the TIP-RC clientele, the client versions were administered to the clients by their assigned clinician. As per the recommendations of the 2013 TIP-RC Evaluation (Barnett, 2013), both instruments were supposed to be translated into Krio, but this recommendation was not followed by WHI. Thus, the clinicians interpreted each item of the client versions of the CCAT and PRAT as they administered them to non-English speaking clients. It is also important to note that the wording on the all the scales were based on Sierra Leone English, not American English (e.g., CCAT-Client Item 8 used the word "conscious" to measure "on guard").

The CCAT and PRAT include adapted items (based on feedback from the TIP-RC clinical staff) from the Oxford Measure of Psychosocial Adjustment (MacMullin & Loughry, 2004), and the PTSD-8 (Hansen et al., 2010). The Oxford Measure of Psychosocial Adjustment was validated to assess culturally relevant indicators of psychosocial adjustment in former child soldier in Sierra Leone and Northern Uganda, and it was designed to evaluate the outcomes for reintegration programs for child soldiers. Betancourt, Brennan, Rubin-Smith, Fitzmaurice, and Gilman (2010) used a 46-item version of this inventory in their prospective longitudinal study on the reintegration outcomes of former child soldiers in Sierra Leone. They found it had sound reliability and validity, including strong correlations with standard measures of psychological problems commonly used with war-affected youth (i.e., the Child Posttraumatic Stress Disorder Reaction Index and the 25-item Hopkins Symptom Checklist). The items in the following scales on the CCAT and PRAT are based heavily on the corresponding scales from the Oxford Measure of Psychosocial Adjustment: Anxiety & Depression, Hostility, Prosocial Behavior, and Confidence. The Trauma scale in both the CCAT and PRAT includes items adapted from the PTSD-8, which was derived from the Harvard Trauma Questionnaire (HTQ) and it has shown acceptable performance compared to longer PTSD screening tools.

In addition, the following CCAT and PRAT scales are based on scaled and adapted items from the TIP-RC's child risk assessment form and family and community risk assessment form:

Physical Health, Educational/Vocational Functioning, Coping Skills, Self-Protection Skills, Family Risk Factors, and Community Risk Factors. Based on WHI's experience providing aftercare services to VoT in Cambodia and Sierra Leone, these scales measure variables that they have found to be useful in determining the protective factors and risk factors that affect reintegration outcomes. Also, since WHI is a faith-based organization, the CCAT and PRAT's Spirituality scale was added based on recommendations by WHI to determine how the TIP-RC Project affects clients' spiritual coping regarding their traumatic experiences. Lastly, the Family Acceptance and the Community Acceptance scales in the PRAT were based on adapted items from Betancourt, Brennan et al. (2010), which were used to measure similar constructs in reintegrated former child soldiers in Sierra Leone.

Table 1 lists the reliability coefficients (Cronbach alphas) for the baseline CCAT scales and the PRAT scales for the present study. The majority of the scales showed acceptable levels of reliability, although items were removed from some scales to obtain stronger reliability coefficients, as indicated in Table 1. However, some scales demonstrated only marginal levels of reliability, which could be partially related to the small sample size used in this study. Also, the Prosocial Behavior, Spirituality, Coping Skills, and Self-Protection Skills scales obtained higher reliability coefficients on the PRAT than the CCAT, even though both versions contain the same items. This may indicate that these scales measure factors that are more relevant in Sierra Leonean community life than residential care. However, because the goal of residential care at the TIP-RC is to prepare clients to be reintegrated into normal community life, it makes sense that it is important to assess these factors while clients are still in residential care. However, the Physical Health scale was not used in any statistical analyses due to its unacceptable levels of reliability. Instead, Item 1 from the CCAT-Clinician and PRAT-Clinician was used to measure physical health problems. Also, Table 1 indicates the CCAT and PRAT scales that were reversed scored; therefore, higher scores on all the scales indicate a higher frequency of symptoms or more serious problems. The statistical procedures used to analyze the CCAT and PRAT data will be discussed in Sections 3.5 and 3.6 of this report.

Plan for Human Subject Protections

The research protocol for this study was approved by the Institutional Review Board (IRB) at the evaluator's primary institutional affiliation (Roberts Wesleyan College) for human subject protections. No data was collected until the IRB approved this project. The evaluator obtained informed consent from all the participants who were involved in the semi-structured interviews and direct observations (see Annex 10 and 11 for the informed consent forms). Participation in the semi-structured interviews was voluntary, and participants could refuse to answer any questions or stop at any time without penalty. Because WHI values the potential benefits of this evaluation project in regards to improved clinical care, participation in the direct observations of staff members' normal job responsibilities was not voluntary. However, WHI employees were informed that the data collected would not be used for employee performance reviews or other employment-related issues.

All collected data, including interview notes, direct observations recording sheets, archival data, and program documentation, remain strictly confidential. No identifying information was collected in this project, and all findings are reported in aggregate form with no identifying information. All archival data was coded using client ID numbers. In addition, all collected data

is stored in a locked cabinet or a password protected computer in the evaluator's office. Only this evaluator has access to the data.

Table 1

Reliability Coefficients and Reverse Scoring for CCAT and PRAT Scales

Scales	CCAT α	PRAT α	Scale Reversed Scored
Trauma	.80	.67	
Anxiety & Depression	.86	.81	
Hostility	.89	.84	
Prosocial Behavior [a]	.50	.90	Yes
Confidence [b]	.51	.54	Yes
Spirituality	.48	.78	Yes
Physical Health	-.11	-- [e]	
Educational/Vocational Functioning	.93	.96	
Coping Skills	.63	.77	
Self-Protection Skills	.51	.77	
Family Acceptance & Support [c]		.71	Yes
Community Acceptance [d]		.49	Yes
Family Risk Factors		.72	
Community Risk Factors		1.00	

[a] Items 44 and 53 from the CCAT-Client and PRAT-Client were removed.
[b] Item 59 from the CCAT-Client and PRAT-Client was removed.
[c] Item 65 from the PRAT-Client was removed.
[d] Item 73 from the PRAT-Client was removed.
[e] The Cronbach alpha could not be computed due to the lack of variance.

1.4 EVALUATION LIMITATIONS

This evaluation study establishes the level of outcomes for the TIP-RC Project in regards to building staff capacity, achieving the stabilization and recovery of VoT, and successfully reintegrating VoT in the Sierra Leone community. However, because this study used a non-experimental design to evaluate this project, definitive causal relationships cannot be established between program inputs, outputs, and outcomes. Therefore, all findings about what factors contribute to the outcomes must be considered as suggestive, rather than conclusive. The lack of an experimental design is an inherent difficulty in studying human trafficking aftercare services because of the ethical limitations of randomly assigning identified victims to controls groups (i.e., providing them with no treatment or support services). In addition, due to the paucity of research on reintegration outcomes (Barnett, 2013) and the limited number of program evaluations for human trafficking aftercare programs (Potocky, 2010; Rafferty, 2013), there are no established norms of effective outcomes for trafficking victim assistance programs. This limits the ability to compare the results of this evaluation to established criteria of aftercare outcomes.

Another limitation of this study is that the robustness of the outcome data collected via the CCAT and PRAT has been negatively affected by the lack of fidelity during administration procedures. For example, TIP-RC staff members did not consistently administer both the CCAT-Client and CCAT-Clinician at all three administration periods to all clients, making the data set incomplete and reducing the power of the statistical analyses completed. Also, the validity and reliability of the CCAT and PRAT could be negatively impacted by the lack of a standard Krio translation of the assessment tools. The internal consistency of the Physical Health scale, Confidence scale, and Community Acceptance scales were weak, so these scales need to be augmented with other questions or different measurements for future research studies. It is also important to note that due to using self-report measures, the potential biases of the respondents could affect the outcome data. Given these issues as well as the small sample size of the data collected, the findings from the CCAT and PRAT should be considered as exploratory and not as authoritative.

Although interviewing the TIP-RC clients could have provided beneficial information, this option was not utilized due to the fact that all the clients are traumatized individuals, who are mostly minors, in a vulnerable position. It would be difficult for clients, especially children, to give accurate perceptions of the TIP-RC while still receiving residential care or reintegration support services from WHI (Brunovski & Surtees, 2010). It is also only recommended to use direct methods (e.g., interviews) to collect research data with minors in international settings, if the necessary information is not available through other data sources (Schenk & Williamson, 2005). However, for this evaluation project, the necessary data to answer the research questions were available through other means, including the information obtained from the case file analyses. Moreover, only interviewing adult clients who have been fully discharged from the program would have provided a small, non-representative sample of the clientele. Because interviewing adult female trafficking survivors has the potential to increase the likelihood of physical or psychological harm, including possible re-traumatization (Brunovski & Surtees, 2010; Zimmerman, 2003), it was determined that the benefits of interviewing TIP-RC clients did not outweigh the possible limitations and risk factors. In addition, in order to protect client confidentiality and the safety of the therapeutic process, individual counseling sessions were not directly observed during the field research.

2.0 BACKGROUND

2.1 BACKGROUND ON TIP IN SIERRA LEONE

According to the 2016 Trafficking in Persons Report (U.S. Department of State, 2016), Sierra Leone is a source and destination country for TIP. Men, women, and children are most commonly trafficked from rural areas to urban areas for the purpose of exploitation in forced labor (e.g., in mining, fishing, or agricultural sectors as well as petty trading and begging), domestic servitude, prostitution, and forced marriages. There is evidence that transnational trafficking to and from Sierra Leone has recently increased (U.S. Department of State, 2016). There are reports that Sierra Leoneans have been trafficked to other West African, European, and Middle Eastern countries, whereas Sierra Leone has been a destination country for individuals trafficked from Asia and other African countries, especially from West Africa. Key informants for the current evaluation reported that Guinea may be a common transit country for Sierra Leoneans being trafficked to other West African countries. Rates of human trafficking in Sierra Leone are unknown because data collect on TIP issues are weak (Surtees, 2005; United Nations Children's Fund, 2005; U.S. Department of State, 2016).

There has been little research conducted on human trafficking in Sierra Leone, besides a preliminary assessment of child trafficking in 2005, which found that child trafficking was a common occurrence in Sierra Leone (Surtees, 2005). At the time of this assessment, child trafficking primarily involved internal trafficking from rural to urban areas for the purpose of forced labor (e.g., domestic work, mining, fishing, and agriculture) or sexual exploitation (e.g., sexual servitude and prostitution). Surtees found that one of the most common forms of child trafficking in Sierra Leone involved rural children being trafficked to urban areas to perform domestic labor in exploitative conditions, often involving neglect, physical abuse, or sexual violence. Frequently, the perpetrators are family members who deceive the children or their parents with the promise of educational opportunities.

2.1.1 Causes of TIP in Sierra Leone

Human trafficking in Africa has been attributed to high rates of poverty, which are exacerbated by a cultural climate that often tolerates a high prevalence of gender discrimination and gender-based violence (UNICEF, 2005). According to Sawadogo (2012), transnational human trafficking in West Africa is due to two main causes: socio-economic factors and politico-institutional factors. Socio-economic factors include ". . . limited economic alternatives, disparate socio-economic conditions, regional imbalances, feminization of poverty, discrimination against women, patriarchal socio-cultural structures, lack of social supports for single mothers, shortage of employment and professional opportunities, and the universal greed for money and power" (Sawadogo, 2012, p. 102). These factors are exacerbated by high rates of illiteracy and the lack of awareness about human trafficking in West Africa. Politico-institutional factors related to transnational human trafficking in West Africa include the lack of anti-trafficking laws, limited enforcement of these laws, the lack of political will, insufficient expertise by authorities to combat TIP, widespread political corruption, porous borders, poor inter-country information sharing, and the absence of reliable data on TIP.

Surtees (2005) noted that the causes of TIP in Sierra Leone are similar to other countries, including ". . . economic causes (poverty and material aspirations), political and legal factors (war, corruption, porous borders), cultural factors (normative migration, child labour, early marriage, etc.), social condition (limited education, violence in the home) and individual characteristics (rebellion and peer influence)" (p. 4). According to the 2015 Human Development Report (United Nations Development Programme, 2015), Sierra Leone is listed as having low levels of human development and is ranked 181th out of 188 countries. Therefore, TIP in Sierra Leone is exacerbated by the following development indicators: (a) high levels of poverty; (b) low levels of educational attainment; (c) grossly inadequate educational, medical, and social systems; and (d) poorly resourced and ineffective government services. Moreover, the common cultural practice of mend pikin (i.e., children being fostered out and raised by someone other than their biological parents in order to secure better education or work opportunities) often allows parents to cope with these low development indicators, but it also contributes to child trafficking. Child fostering can mask exploitation and contribute to the use of deception during trafficking acts, especially since the general population has limited awareness about both TIP and the risks of mend pikin (Doherty, 2012; Sawadogo, 2012; Surtees, 2005). In addition, the lack of legal documentation, due to the low rates of birth registration in Sierra Leone, makes transnational trafficking easier to accomplish (Doherty, 2012; UNICEF, 2005).

2.1.2 Government Efforts to Combat TIP

According to the 2016 Trafficking in Persons Report (U.S. Department of State, 2016), Sierra Leone is currently listed as Tier 2 country; the Government of Sierra Leone (GOSL) has made efforts to eliminate TIP, even though it does not fully meet the minimum standards set by the Trafficking Victims Protection Act (TVPA). The GOSL sustained modest efforts in the areas of prevention, protection, and prosecution of human trafficking. Although the Anti-Human Trafficking Act of 2005 prohibits all forms of human trafficking in Sierra Leone, its penalties are not sufficiently stringent. Moreover, the prosecution of human trafficking cases is very low in Sierra Leone, and key informants stated that there has only been one trafficking conviction since the law was enacted in 2005. There are problematic systemic issues in the judiciary, including procedural inefficiencies and corruption. Also, all sectors of society, including government social workers, police officers, and prosecutors, need more training and education on TIP-related issues. Therefore, victim identification and data collection remain problematic, even though the TIP National Task Force recently implemented a national referral mechanism. Also, the GOSL provides limited victim assistance and legal representation to identified victims. However, it does not provide any funding to non-governmental organizations (NGO) providing victim assistance. Surtees (2005) noted that the GOSL lacks sufficient structure, resources, or capacity to effectively implement anti-trafficking efforts; therefore, anti-trafficking work is mostly conducted by NGOs in Sierra Leone with little or no government funding.

2.2 BACKGROUND ON THE TIP-RC PROJECT

WHI is a faith-based, relief and development NGO founded in 1996. Its main headquarters are in Alexandria, VA, and it operates in 15 countries around the world. WHI began working in Sierra Leone in 1997 to provide war relief in response to the Sierra Leone civil war. WHI partners with the Wesleyan Church in Sierra Leone to provide relief and development programs. In 2004, WHI began combatting human trafficking in Sierra Leone as part of the FAITH consortium, which

then changed to the FAAST consortium. WHI and World Relief were the only FAAST implementing partners in Sierra Leone until World Relief pulled out of the country in 2008. Since then, WHI has been the only NGO combatting human trafficking in Sierra Leone.

From 2004-2008, FAAST's anti-trafficking projects were focused primarily on prevention, including public awareness compaigns and advocating on TIP-related issues with the GOSL. During this time period, FAAST started the VPGs, which are community groups comprised of community stakeholders who provide education on TIP, gender-based violence (GBV), and forced labor in their local communities. They are also trained in victim identification, basic victim assistance, and legal advocacy, including police and court monitoring. Each VPG is essentially self-supporting through the use of income generating projects. Currently, VPGs are located in 58 different Sierra Leonean communities.

From 2008-2012, WHI developed the Rapid Response Project as a result of the increased identification of VoT due to their prevention projects. Through this project, social workers provided case management services to meet the immediate needs (e.g., clothing, food, medical care, and referrals for residential care) of identified victims. According to key informants, it became clear to WHI and the VPGs that the residential care available at that time was not adequate or appropriate for the needs of VoT. Residential care was primarily available at shelters for street children or orphanages, which often provided low quality of care due to limited enforcement of residential care guidelines by the GOSL. Housing VoT with other vulnerable populations, including street children, is problematic, and it is not a recommended practice for trafficking victim assistance programs (Macy & Johns, 2011). Moreover, because the identified victims in the Rapid Response Project did not receive any trauma care or reintegration support services at these alternative care placements, the VPGs were concerned about the high rates of poor reintegration outcomes and they began advocating for WHI to start a shelter. In short, the need for a specialized TIP shelter in Sierra Leone stemmed from the success of WHI's TIP Prevention Program and the resulting increase in identified victims as well as the lack of appropriate aftercare services in Sierra Leone.

WHI secured funding from J/TIP to start the TIP-RC Project, and the shelter began operating in May 2012. It operated under normal capacity until August 1, 2014 when a National State of Emergency was declared due to the Ebola epidemic in West Africa. The TIP-RC then halted all new residential admissions to prevent the spread of Ebola into the shelter, and they also delayed all further reintegrations due to Ebola-related travel restrictions. Normal activities slowly started back up in February 2015 as government travel restrictions were relaxed. However, all residential clients were reintegrated by July 2015, regardless of the course of their treatment, because the shelter closed for 3 months due to a lapse in funding. In October 2015, the shelter was reopened after WHI secured a 1-year cost extension grant from J/TIP. Also, it is important to note that the WHI's TIP Prevention Program is not currently funded; thus, the TIP-RC Project is currently the only funded anti-trafficking project in Sierra Leone.

2.2.1 Project Goals and Logic Model

The primary goal of the TIP-RC Project is to provide holistic and comprehensive care to human trafficking survivors in order to support their recovery and successful reintegration into the Sierra Leone community. Another goal of the project is to strengthen systems and infrastructure

in order to develop a sustainable approach to combatting TIP in Sierra Leone. Annex 12 contains a logic model of the TIP-RC Project. It identifies the main assumptions and external factors affecting the program design, and it also explains the relationship between program inputs (e.g., resources used to generate program activities), outputs (i.e., program activities and participants), and outcomes. The TIP-RC program design is based on a victim-centered approach. "A victim-centered approach provides a systematic focus on the individual's needs and concerns to ensure compassionate and sensitive delivery of services in a nonjudgmental manner" (Alvarez & Canas-Moreira, 2015, p. 2). Also, WHI believes it is paramount to meet international standards for trafficking victim assistance programs, including utilizing quality child protection practices, while also contextualizing the service delivery model for the Sierra Leone context. The program design also emphasizes collaborating with implementing partners to provide comprehensive care. According to a WHI respondent, "we cannot do this work alone and we need to do this in collaboration with other NGOs and government agencies." Lastly, the clinical treatment model utilized in the TIP-RC Project emphasizes the importance of the therapeutic relationship in the recovery process for trafficking survivors. One clinical staff member stated, "We believe people are harmed in relationships and are healed in relationships."

2.2.2 Facilities

Administrative support for the TIP-RC Project is located in WHI's main office in Freetown, whereas residential care is provided in a large house within a walled compound in a residential neighborhood in the Freetown area. The shelter is located at an undisclosed location due to confidentiality and safety issues, while a security guard is located on premises at all times. The aftercare service delivery literature recommends that residential care for child trafficking survivors should be provided in a safe, secure, and developmentally appropriate shelter (Macy & Johns, 2011; Muraya & Fry, 2016). The residential care provided by the TIP-RC Project meets this standard as evidenced by: (a) the shelter is sufficient in size for its operating capacity; (b) rooms are equipped with basic, yet appropriate furniture and toys; (c) sleeping areas are separated based on age; and (d) a large courtyard provides an outdoor play space for children (Barnett, 2013). In addition, the shelter contains a private counseling office with adequate play therapy supplies and also a basic classroom with desks and chalkboards. A staff meeting area and an office are contained in a separate building on the compound. Originally, the shelter did not have running water (Barnett, 2013), but this problem has since been remedied. In addition, the shelter has a generator to provide electricity due to the unreliability of electricity in Sierra Leone. This evaluation concurs with the 2013 TIP-RC evaluation that, "Overall, the shelter is clean and well organized, offering a pleasant and comfortable living situation" (Barnett, 2013, p. 16).

2.2.3 Characteristics of the Staff

The current composition of the TIP-RC staff includes: 1 Shelter Manager, 1 Trauma Care and Protection Specialist (TCPS), 2 Social Workers, 2 Counselors, 1 Teacher, 1 Nurse, 10 House Parents, 2 on-call House Parents, 2 Cooks, 2 Drivers, 1 Cleaner, 4 Security Guards, and 1 Bookkeeper. The Shelter Manager is responsible for all program operations, and the TCPS is in charge of overseeing the clinical care provided at the TIP-RC Project. Thus, the Shelter Manager provides managerial supervision for all staff members, whereas the TCPS provides clinical supervision to the clinical staff members (i.e., social workers and counselors) and provides training and coaching to build staff capacity. The Shelter Manager and TCPS report directly to the Vice President of Programs at WHI's main headquarters, but they also report in-country to

the Sierra Leone Country Director. The Country Director provides managerial support, including advice and support for day-to-day issues, whereas the Vice President of Programs provides more support in regards to project implementation and funding. In addition, the TIP-RC Project receives additional in-country technical support, especially during management team meetings, from the WHI Anti-Trafficking Technical Advisor and the WHI TIP Prevention Director, even though these staff members are supported via other funding sources.

Residential care is primarily provided by the House Parents, which includes 3 House Parent Team Leaders and an Activities Coordinator. Three House Parents, including one House Parent Team Leader, are on duty at all times. When the shelter is over-capacity (i.e., more than 20-22 residential clients), 4 House Parents are utilized for each shift to adequately supervise the additional clients. During business hours, the Nurse, the Teacher, and two Counselors also work on-site at the shelter and assist with the residential milieu. One Social Worker and one Counselor are assigned to each case. The Social Workers are stationed at WHI's main office in Freetown, although they regularly work in the field since they are primarily responsible for screening referrals and providing the reintegration support services. The Counselors are responsible for meeting the psychosocial needs of the residential clients, including providing individual counseling, group counseling, and life skills training. Both Social Workers and Counselors are also involved in monitoring reintegrated cases and providing services to non-residential clients. The caseloads of the clinical staff members are about 10-12 residential clients per staff member and 30 reintegrated or non-residential clients per staff member. Key informants consistently stated that the current staffing levels are not sufficient for the Social Workers and Counselors, especially due to the amount of travel that is necessary for the provision of reintegration support services and the increased numbers of non-residential clients receiving case management services.

All staff members are female, except for one House Parent/Activity Coordinator, the Security Guards, and the Drivers. Also, all staff members are Sierra Leoneans, except for the TCPS. Currently, the TCPS is an American mental health counselor who is licensed in Washington State. The rest of the clinical staff members have some post-secondary education, yet none of them have a 4-year college degree. This reflects the lack of educational opportunities and the limited development of the social service field in Sierra Leone, which is common in low resourced countries (Surtees, 2013). However, both of the Counselors and one of the Social Workers were trained as mental health interventionists for the Youth Readiness Intervention, which was a successful evidenced-based group intervention for distressed, war affected youth in Sierra Leone (Betancourt, McBain, Newnham, et al., 2014; Newnham et al., 2015).

Although the TIP-RC has struggled with recruiting well qualified staff members (see discussion in Section 2.2.7), it has excellent staff retention in that they have only lost 2 staff members in the last 3 years. This is an improvement from the 50% staff retention rate during the TIP-RC's first year of operation (Barnett, 2013). The initial staff retention problems were related to the difficulty of finding qualified staff members with a good fit to the program. However, key informants believe another important reason for the improvement is the intentional development of a team-based approach marked by collaboration, support, and open communication. These characteristics were evident during the direct observations of the weekly staff meetings, which include the management team meeting, the case management team meeting, and the house parent

meeting. During all three of these meetings, it was clear that staff members had supportive, collegial relationships with each other, and they used these meeting to collaboratively process problems and brainstorm solutions.

2.2.4 Admission Criteria

The TIP-RC Project has provided comprehensive aftercare services to mostly female minors, although they have admitted some young boys and young adult women. From 2012 until the shelter closed in July 2015, the admission criteria for residential care required one of the following presenting issues: (a) a victim of human trafficking (as defined by the 2005 Anti-Human Trafficking Act), or (b) a victim of rape/sexual abuse that is vulnerable to trafficking due to high levels of trauma, on-going security needs, or unmet medical needs. During this time period, 52% of the residential clients were VoT, whereas 38% were rape/sexual abuse victims. In addition, 9% of the residential clients involved other types of trauma cases (e.g., abandoned children) that did not meet the admission criteria, but were admitted due to their high risk for death or serious impairment. As per one of the recommendations in the 2013 TIP-RC Evaluation (Barnett, 2013) and due to J/TIP's expectation that trafficking victims (or those vulnerable to trafficking) are the primary beneficiaries of residential care, WHI tightened the admission criteria for residential care in 2013. Thus, other trauma cases were not admitted to the shelter after its first year of operation. The TIP-RC also provided case management services for non-residential clients, including: (a) male VoT between the ages of 10 and 17, and (b) referrals meeting the admission criteria when the shelter was full and not accepting new residential clients. During the Ebola period when the shelter was on lockdown from August 2014 until February 2015, all TIP-RC referrals were provided case management services only.

When the TIP-RC reopened in October 2015, WHI further tightened the admission criteria to only provide residential care to victims of human trafficking (as defined by the 2005 Anti-Human Trafficking Act) that are children (i.e., female minors and males under the age of 10) and young adult women. Still, they will admit suspected human trafficking cases "to be on the safe side," according to one respondent. Since the TIP-RC reopened, 93% of the residential clients have been VoT, whereas 7% have been suspected TIP cases that turned out not to involve trafficking (e.g., one case involved rape and the other case involved labor exploitation and child neglect). In addition, the TIP-RC continues to provide case management services for non-residential clients, which sometimes includes arranging residential care with alternative care providers. These non-residential clients can include: (a) male VoT between the ages of 10 and 17; (b) female VoT when the shelter is full and unable to accept additional residential clients; and (c) GBV referrals that are at risk for trafficking. Since the TIP-RC reopened, 89% of non-residential clients have been male VoT under the age of 18, and 11% have been GBV referrals at risk for trafficking.

2.2.5 Characteristics of the Clientele

From 2012 until the shelter closed in July 2015, 80 residential clients (63 during the pre-Ebola period and 21 during the Ebola period) received comprehensive aftercare services at the TIP-RC, including 77 reintegrated clients and 3 transferred to other service providers. The mean age of these residential clients was 11, ranging in age from 2 to 23. Females made up 95% of all residential clients. During the same timeframe, 18 non-residential clients received case management services, including 4 during the pre-Ebola period and 14 during the Ebola period.

The mean age of these non-residential clients was 14.5, ranging in age from 3 to 35. The gender make-up of these non-residential clients included: 50% female, 11% male, and 39% none listed.

From October 2015 until the time of the field research, 37 residential clients have received comprehensive aftercare services at the TIP-RC, including 12 reintegrated clients and 25 clients currently in residential care. During the same timeframe, 19 non-residential clients received case management services, including 18 that are currently receiving residential care at alternative care providers. During the course of the field research, the TIP-RC received 17 new referrals, including 7 of the 37 residential clients and 10 of the 19 non-residential clients. Note that these 17 cases were not included in the below descriptive statistics because their case registration forms were still in process of being completed at the conclusion of the field research. The mean age of the residential clients (n = 30) is 13.1, ranging in age from 6 to 25. Additional detailed information about the residential clients' demographic information is included in Table 2.

For trafficking clients in residential care (n = 28), the mean total time spent in trafficking was 13.8 months, ranging from 2 days to 9 years. Table 3 lists more detailed information about these trafficking clients. For 8 of the trafficking cases, the clients were intercepted while in transit before the intended exploitation occurred. These cases are routinely admitted to the shelter to prevent spontaneous reintegrations (i.e., reunification with family members without adequate assessment of family and community risk factors) and to minimize the risk of re-trafficking. According to key informants and Surtees (2005), family members or community members are often the perpetrators of human trafficking in Sierra Leone, which is also seen in the TIP-RC cases. The use of deception about the promise of education for minors or job opportunities for adults is the most commonly used trafficking means for the TIP-RC clientele. From 2013-2016, about 75% of the trafficking clients in residential care were victims of labor trafficking, with the vast majority experiencing domestic servitude, whereas 25% were sex trafficking victims. However, since the shelter reopened in October 2015, there has been a much higher rate of clients being victims of labor trafficking, as evident in Table 3. Please note that all information included in Tables 2-3 was obtained from WHI's Data Sheet and the case registration forms in the case files; thus, they only contain information that was known at admission and may not give the full picture of some of the variables listed.

Since the shelter reopened in October 2015, 12 of the 37 residential clients have been reintegrated. For these 12 reintegrated cases, the mean length of residential care before reintegration was 96 days (3.2 months). The range was from 59 days (almost 2 months) to 180 days (6 months). Table 4 breaks down the mean length of residential care at the TIP-RC based on different operational time periods. As noted in Table 4, during the pre-Ebola timeframe (i.e., May 2012 until August 2014), the length of residential care dropped markedly from the first year of operation (i.e., clients reintegrated by May 2013) to the second year of operation (i.e., clients reintegrated between June 2013 and July 2014). This could be indicative of improved staff capacity over time, which resulted in more effective and efficient clinical care, decreasing the length of residential care needed to stabilize the clients. The length of residential care increased significantly during the Ebola period (i.e., August 2014 until the shelter closed in July 2015) because the TIP-RC could not reintegrate clients for at least for 6 months or more due to the National State of Emergency and the resulting travel restrictions around the country. Since the

TIP-RC reopened in October 2015, the mean length of residential care has returned to a level that is comparable to the mean during the 2nd year of operation in the pre-Ebola period.

Table 2

Demographic Information for TIP-RC Residential Clients Since October 2015 (n=30)

Demographic	*n*	Percentage
Gender		
Female	30	100%
Age		
Age 6-12	15	50%
Age 13-18	11	37%
Age 19-25	4	13%
Nationality		
Sierra Leone	27	90%
Kenya	2	7%
Liberia	1	3%
Education Level		
No formal schooling	1	3%
Primary school	21	70%
Junior secondary school	4	13%
Senior secondary school	1	3%
Post-secondary education	2	7%
None listed	1	3%
Presenting Issue		
Trafficking victim	28	93.3%
Rape victim [a]	1	3.3%
Labor exploitation/neglect [a]	1	3.3%

Note. The above table does not include cases admitted during the course of the field research
[a] Suspected TIP case at admission

Table 3

Characteristics of the Trafficking Clients in Residential Care Since October 2015 (n=28)

Characteristic	*n*	Percentage
Total Time of Trafficking Event		
Less than 1 month	8	29%
1-12 months	15	54%
More than 12 months	4	14%
None listed	1	3%
Type of Trafficking		
Internal	13	46%
External [a]	15	54%
Trafficking Acts		
Recruitment	27	96%
Transportation	25	89%
Harboring	15	54%
Transfer	14	50%
Receipt of Persons	2	7%
Trafficking Means		
Deception	25	89%
Minor	24	86%
Abuse of Power	12	43%
Force	4	14%
Threats	2	7%
Coercion	2	7%
Fraud	0	0%
Debt Bondage	0	0%

(Table 3 continues)

Table 3 (continued)

Characteristics of the Trafficking Clients in Residential Care Since October 2015 (n=28)

Characteristic	*n*	Percentage
Trafficking Purpose		
Forced Labor or Services	24	86%
Commercial Sexual Exploitation	3	11%
Sexual Servitude	2	7%
Slavery-like Practices	2	7%
Removal of Body Parts	0	0%
Vulnerability Influences		
Education	21	75%
Family Pressure [b]	6	21%
Gender	4	14%
Job Opportunity	3	11%
Domestic Violence	1	4%
Civil Conflict	0	0%
Natural Pressure	0	0%
Other Traumas Experienced During Trafficking Event		
Physical Abuse	7	25%
Rape/Sexual Abuse	3	11%
Movement Restricted	3	11%
Verbal Abuse	1	4%
Neglect	1	4%
Re-trafficked	1	4%
Stigmatized as Demon Possessed	1	4%

Note. The above table does not include cases admitted during the course of the field research.
[a] includes cross-border trafficking to Guinea and Lebanon, and cross-border trafficking from Kenya and Liberia.
[b] includes parental abandonment, neglect, unplanned pregnancy, etc.

Table 4

Length of Residential Care Before Reintegration Based on Operational Time Periods

Operational Time Period	*n*	Days	Months
Pre-Ebola Period	56	168	5.6
1st Year of Operation	21	182	6.1
2nd Year of Operation	35	113	3.7
Ebola Period	21	379	12.6
Post-Ebola Period	12	96	3.2

2.2.6 Intervention Methods

The intervention methods used in the TIP-RC program model include four broad categories: (a) referral services, (b) shelter services, (c) reintegration services, and (d) legal support. Referral services involve providing outreach trainings and advocacy on TIP issues to implementing partners in order to increase victim identification. The TIP-RC Social Workers also screen referrals, admit appropriate referrals for residential care, and provide case management services for non-residential cases. The referral services will be discussed in more detail in Section 3.2 of this report. Shelter services are provided only to the residential clients. All the following services are provided at the shelter with the intended purpose of stabilizing and recovering VoT: (a) short-term residential care; (b) medical care and health education; (c) individual and group counseling; (d) psychoeducation and life skills training; (e) educational and vocational services; and (f) social and recreational activities. Reintegration support services will be discussed in more detail in Section 3.3 of this report. They involve services that prepare and equip clients, families, and communities for successful reintegration, including: (a) family tracing; (b) family bonding visits; (c) family and community assessments; (d) mediation of conflicts that could hinder reintegration; (e) family and community education on TIP issues and child protection practices; and (f) reintegration support packages. Additional reintegration support services that occur post-reintegration include regular monitoring phone calls and community-based follow-up visits. Lastly, the TIP-RC provides legal support, which primarily consists of linking clients with legal representation, advocating for their legal needs, and providing pre/post-counseling for legal events. Additional information about the legal support services will be discussed in Section 3.1 of this report.

2.2.7 Implementation Issues

Key informants described three significant implementation issues that occurred during the course of the TIP-RC Project. Two of these implementation issues will be discussed in more detail in Section 3.1 of this report, but they involve problems when working with implementing partners and problems with obtaining justice for VoT. Being able to recruit and hire qualified staff

members for the TIP-RC Project is the third significant implementation issue identified by WHI staff members.

It is a priority for WHI that Sierra Leoneans are primarily responsible for the anti-trafficking efforts in Sierra Leone. However, as a low-resourced country with no graduate-level training in social work or counseling, as well as having exceeding low levels of educational attainment for females, WHI has struggled with recruiting qualified staff members for the TIP-RC Project (Barnett, 2013). Instead of trying to find staff members with the right degrees or credentials, they recruited staff members with the appropriate soft qualities to be competent caregivers, such as good interpersonal skills and a strong work ethic. According to one respondent, "we obtained the best qualified people we could find and then we did a lot of training." According to a key informant, who has significant experience with capacity building in Sierra Leone, "successful training programs in the country require a significant amount of modeling and hands-on practice in addition to content knowledge" (Barnett, 2013, p. 27). This necessitated the employment of an expatriate staff member with clinical credentials and expertise to fill the TCPS position. The TCPS has offered on-going staff training and clinical supervision to increase the professional capacity of the staff members. For example, all staff members receive initial caregiver training before they can start working with the clientele. The caregiver training uses group work and experiential methods to help staff members develop essential caregiver qualities and skills, while also helping them understand the experiences and needs of trauma survivors (Barnett, 2013). Besides regular refresher trainings on the caregiver skills, additional staff trainings during the course of the project have included: case management skills, trauma-informed care, suicide risk assessment, human rights, first aid arts (i.e., a group counseling curriculum using creative arts to help process trauma), female genital mutilation (FGM) prevention, child protection practices, vehicle safety practices, stress management, and self-care skills. The TCPS also provides clinical supervision to the Social Workers and Counselors during the weekly case management team meetings, and she meets with them for individual supervision as the need arises. In addition, the TCPS coaches the House Parents on caregiver issues at the weekly house parent meeting. There was general agreement between key informants that this has been the key to developing the clinical capacity of the staff members. Section 3.4 of this report will discuss how effective WHI has been in developing their staff capacity.

In addition to these implementation issues, the 2013 TIP-RC Evaluation (Barnett, 2013) offered recommendations to improve the quality of clinical care offered by the TIP-RC Project. WHI has made substantial progress on implementing several of the recommendations, including: (a) clarifying admission criteria; (b) employing an expatriate clinical supervisor to help build staff capacity; (c) implementing the CCAT and PRAT into clinical practice; (d) strengthening partnerships with medical care providers; (e) limiting group membership; and (f) maintaining the cost structure. However, WHI has not made sufficient progress on recruiting a House Parent Supervisor or strengthening the educational services, although the TCPS has increased her mentoring of the House Parents, and the Shelter Manager (who is a certified teacher in Sierra Leone) has mentored the Teacher. Moreover, WHI has not made any progress in improving the vocational services, especially since they did not replace the Vocational Coordinator after she resigned her position. Lastly, the findings from Section 3.4 of this report will indicate that WHI has not made progress on improving their record keeping, even though the TCPS instituted chart audits as recommended in the previous evaluation. However, it is important to note that some of

these recommendations were not fully addressed due to do challenges related to the Ebola epidemic, requiring WHI to prioritize issues that needed to be addressed.

2.2.8 Project Funding and Sustainability Issues

The start-up costs for the TIP-RC Project were covered by a 2-year grant from J/TIP for $500,000. The current on-going costs to run the program are approximately $380,000 per year. The majority of their operating budget comes from a 1-year cost extension grant from J/TIP for $300,000, while WHI supplements the budget with an additional $80,000 per year. As a result of recent high rates of inflation in Sierra Leone, the current budget is not adequate to meet all their expenses, but they try to find ways to cut costs. WHI has not been able to obtain financial support from the GOSL, nor have they been able to obtain grant money from other international donors to help fund the project. Due to these funding limitations, key informants were clear that the TIP-RC Project would have to close without J/TIP funding at this time.

There are two major issues that negatively impact the sustainability of the TIP-RC Project: the high cost of providing quality comprehensive care and the lack of funding from the GOSL. Although providing comprehensive aftercare services is the gold standard in trafficking victim assistance programs (Macy & Johns, 2011; Muraya & Fry, 2016), it is much more expensive to provide comprehensive services, especially specialized residential care, than provide community-based services. Yet, there is some preliminary evidence that VoT have better reintegration outcomes when they are provided comprehensive aftercare services (Surtees, 2013). In addition, it is labor intensive to provide a high standard of care for children in residential care because there needs to be a higher staff to client ratio for around the clock coverage. According to key informants, it has been an organizational and leadership priority at WHI to have appropriate staffing levels and appropriate child protection policies at the TIP-RC, even though this increases the cost of care.

The other major issue affecting sustainability is the lack of commitment from the GOSL to provide funding to the TIP-RC Project. Key informants at both the MSWGCA and FSU reported that the GOSL highly values the services provided by the TIP-RC Project, and it would be extremely difficult for them to provide assistance and protection to VoT if the shelter closed. Yet, the MSWGCA respondent stated that the Ministry is unable to operate a shelter on its own due to its highly limited budget and low levels of staff capacity. As result, the MSWGCA focuses on initiating policy and monitoring implementation, but it almost completely depends on NGOs to implement the actual service provision.

In 2015, the previous Minister of the MSWGCA stated that he was not opposed to funding the TIP-RC Project for its 3-month budget lapse in order to prevent the shelter from temporarily closing. Key informants at WHI stated that they submitted a budget and attempted to meet with the Permanent Secretary of the MSWGCA (who is in charge of logistics and budgeting), as they were directed. However, nothing came from these efforts, and the Permanent Secretary and the new Minister of the MSWGCA have yet to respond to meeting requests from WHI. The MSWGCA key informant stated that there is a budget line to help support social welfare institutions and the Ministry wanted to provide funding for the TIP-RC through this budget line. However, this budget line is not currently funded and it is unknown when it will be funded. Although respondents have stated that government funding has been more problematic since the

Ebola epidemic, the MSWGCA has historically been the lowest funded and most poorly resourced ministry in the GOSL. Despite this, some key informants stated that they believe that the GOSL could provide additional funding for the TIP-RC Project, but it is not currently a priority for them and there is not enough political will from the professional staff at the MSWGCA to advocate for the needs of vulnerable populations. Even though these funding issues are common place for trafficking victim assistance programs in low resourced countries (Adams, 2011; Surtees, 2013), the 2016 Trafficking in Persons Report recommends that the GOSL "increase partnerships with NGOs providing assistance to trafficking victims and support their efforts either financially or through in-kind support" (U.S. Department of State, 2016, p. 332). Moreover, the United States Ambassador to Sierra Leone plans to advocate for the TIP-RC's funding needs to the new Minister of the MSWGCA.

One WHI respondent stated that if there is not sufficient funding to continue operating the TIP-RC Project, WHI will most likely close the shelter, but continue to provide community-based case management services to VoT. This will be similar to the services that WHI offered during the Rapid Response Project, which they consider to be a "step backwards" and will be insufficient to fully meet the needs of identified victims. Still, key informants reported that the project results that are likely to continue after the TIP-RC Project ends include: (a) better awareness about TIP issues in the Sierra Leone community and the GOSL; (b) better understanding about victim identification and victim protection services by the MSWGCA and SLP; and (c) the increased professional capacity of TIP-RC staff members who will benefit future social service providers in Sierra Leone.

3.0 FINDINGS

3.1 COOPERATION WITH PARTNER ORGANIZATIONS

According to Rafferty (2013), one promising prevention strategy to reduce child trafficking involves developing interdisciplinary and collaborative partnerships with government agencies, law enforcement, human service providers, and community-based organizations (CBOs). Additionally, adequate victim identification and service provision require the development of these interdisciplinary and collaborative partnerships, especially since victim assistance programs often have limited resources (Gjermeni & Van Hook, 2012; Macy & Johns, 2011; Okech, Morreau, & Benson, 2011; Reimer, Langeler, Sophea, & Montha, 2007; Surtees, 2013). Based on a systematic literature review of recommended aftercare service delivery practices for sex trafficking victims in the United States, Macy and Johns (2011) found that securing comprehensive victim assistance is difficult, even in a well-resourced country, without inter-agency collaboration between service providers. "Thus, nearly all of the documents reviewed strongly recommend that coordinated networks of providers should be available to sex trafficking survivors either through referral or by administration through one central organization" (Macy & Johns, 2011, p. 89). In fact, Potocky (2010) found in a program evaluation of a trafficking victim assistance program in Florida, client goal attainment was hampered by poor coordination between service providers, which was partly related to staff turnover at the partner agencies. Furthermore, proactive victim protection and assistance require collaboration between government agencies and NGOs that meet regularly through task forces or committees (Sigmon, 2008).

3.1.1 Implementing Partners

The inter-agency TIP National Task Force of Sierra Leone was stablished in 2005 as part of the Anti-Human Trafficking Act in order to coordinate the implementation of this legislation. This consulting body meets weekly and is co-chaired by the MSWGCA and the Ministry of Justice. It is composed of representative from 15 other government agencies, while WHI and other NGOs working on TIP issues in Sierra Leone are considered co-opted members. Sawadogo (2012) stated that West African governments often lack the political will as well as the expertise to combat TIP; thus, NGOs have been the biggest players in fighting human trafficking in West Africa. This has been the case in Sierra Leone for the TIP National Task Force. For instance, key informants stated that only 6 of the 17 government agencies regularly participate in meetings, and even the co-chair, the Ministry of Justice, inconsistently attends the meetings. Key informants at implementing partners consistently reported that WHI is a "key player" on the TIP National Task Force. One respondent stated, "WHI plays a key role, they are always there, and they always provide advice. They are very knowledgeable on TIP." Also, it was reported that the TIP National Task force meetings are not as effective when WHI is not there because they are "one of the prodders."

Key informants also reported that one of WHI's strengths as an organization is relationship building with other organizations. Even before starting the TIP-RC Project, WHI regularly attended both the TIP National Task Force and the National Child Protection Committee meetings in order to network and build relationships with partner organizations to assist with their TIP Prevention Program. As a result, this made it easier for the TIP-RC to develop

collaborative relationships with both government agencies and other organizations. Also, the TIP National Task Force and other implementing partners were supportive of the TIP-RC Project from the beginning because they trusted and respected WHI for their previous trafficking work in Sierra Leone. Thus, the TIP National Task Force has provided official recognition and support for the TIP-RC Project.

The TIP-RC's program model is built on the premise that it is highly important to build and maintain collaborative partnerships at all levels of Sierra Leonean society because it decreases program costs while increasing the quality of care. Table 5 provides an overview of the TIP-RC's main implementing partners, along with the services provided by these organizations in their service delivery model. It also indicates if the TIP-RC has developed a memorandum of understanding (MOU) with these various partner organizations. Several of these organizations refer identified victims to the TIP-RC as well as provide support services to either non-residential clients, residential clients, or reintegrated clients. For example, almost all medical care provided to residential clients is offered through outside medical providers, which is then coordinated and monitored by the TIP-RC Nurse. Although key informants at WHI stated that they have been successful in developing interdisciplinary and collaborative partnerships, they still need to develop partnerships with legal aid providers or human rights organizations in order to improve the legal support provided by the TIP-RC Project.

One of the implementation issues faced by the TIP-RC involves having to work with implementing partners who do not consistently follow the policies established by the TIP National Task Force. The most common problem is that some implementing partners are inconsistent in following the TIP national referral mechanism, which results in decisions not being made in the best interest of the victims. For example, according to law enforcement procedures in Sierra Leone, the FSU is responsible for investigating child TIP cases and the Transnational Organized Crime Unit (TOCU) is responsible for investigating adult TIP cases. Yet, TOCU does not always refer child cases to the FSU, which negatively impacts legal cases. Also, during the course of the field research, it took the TIP-RC two weeks – which involved multiple meetings with government officials and three trips to another city located three hours away – before they were able to obtain custody of five child trafficking victims. This was because local MSWGCA officials did not follow the TIP national referral mechanism. Instead, these officials attempted to reunify the trafficking victims with their families without any psychosocial care or assessment of family and community risk factors.

Key informants at the TIP-RC believe that these problems are due to numerous factors, including: (a) the lack of understanding about TIP and victim protection practices; (b) a low priority placed on protecting women and children; and (c) corruption. WHI has responded to these challenges by continually addressing these problems at the TIP National Task Force meetings, advocating for victim protection practices at all levels of the GOSL, and providing trainings on TIP-related issues with implementing partners. Moreover, as an organization, they have emphasized relationship building with implementing partners in order to improve these problems. For example, the TIP-RC Social Workers visit FSU stations while they are in the field in order to establish relationships with the police officers and the MSWGCA social workers who are stationed at these locations. Also, WHI has been diligent in building relationships with the FSU and the MSWGCA at the national level.

Due to their focus on advocacy and relationship building, TIP-RC staff members believe they have developed good relationships with their implementing partners. Across the board, the key informants from partner organizations echoed this sentiment, stating they had a "strong relationship," "very positive and close relationship," and "most vibrant partnership." Most organizations believed it was quite easy to work with WHI, stating that the TIP-RC staff members are very responsive, cordial, and helpful. One respondent stated that her organization was "very appreciative because they are always there when we need them. We admire their work and zealousness." Most found the services provided by the TIP-RC Project helped them fulfill their organizations' mission to assist vulnerable people. In fact, the only partnership related problem mentioned by implementing partners was the difficulty they experienced when the shelter was full and not admitting new residential clients, which indicated how much they valued the services provided by the TIP-RC Project. In short, it is clear that the TIP-RC has developed strong relationships with a wide range of partner organizations, which has improved its ability to provide comprehensive victim protection services in Sierra Leone. However, gaps remain in its ability to provide legal support to VoT due to systematic problems in the legal system and WHI's limited partnership development in this area.

Table 5

The Services Provided by Implementing Partners in the TIP-RC Service Delivery Model

Organization	MOU Developed	Services Provided to the TIP-RC
Government Agencies [a]		
MSWGCA		Referrals; approves all admissions; provides guardianship for minors; assists with family tracing, reintegration process, and follow-up with reintegrated cases (if field workers are available); registers TIP-RC to provide child welfare services in SL
Office of National Security		Consults on cross-border TIP cases
Sierra Leone Police		
FSU		Referrals; police investigations of child TIP cases; files charges against perpetrators
TOCU		Referrals; police investigations of adult TIP cases; files charges against perpetrators
Medical Providers [b]		
AWC	Yes	Referrals; free outpatient medical care, prenatal care, and maternity services
Blue Shield Hospital	Yes	Discounted inpatient and surgical medical care
Rainbo Initiatives	Yes	Referrals; free sexual health care and basic counseling services for sexual exploitation cases; provides forensic medical certification
Emergency Hospital		Free surgical medical care for urgent cases
Mental Health Coalition		Provides psychiatric medication
Solthis		Referrals; provides access to antiviral medication for HIV+ cases

(Table 5 continues)

Table 5 (continued)

The Services Provided by Implementing Partners in the TIP-RC Service Delivery Model

Alternative Care Providers		
Variety	In Process	Referrals; all alternative care providers have selected beneficiaries, but will provide interim residential care for non-admitted referrals who need residential care (boys over 10 and VoT when the shelter is full); some will provide long-term residential care for cases that cannot be reintegrated with family members
Cap Anamur		
Child Rescue Center		
Don Bosco		
Jonathan Care Center		
Rainy Season		
St. George's Foundation		
Other NGOs & CBOs		
Human Rights Organization		Referrals; advocates for legal cases
Save the Children		Referrals; assists with family tracing
WMF		Referrals; community sensitization on TIP, assists with the reintegration process and follow-up with reintegrated cases
VPGs		Referrals; community sensitization on TIP; advocates for legal cases, including police and court monitoring; assists with family tracing, the reintegration process, and follow-up with reintegrated cases

[a] TIP-RC also has some interaction with the Ministry of Foreign Affairs, Ministry of Justice, Ministry of Labor, and Immigration Department.
[b] TIP-RC also uses GOSL hospitals for specialized care (e.g., optometry) not provided through other medical providers.

3.1.2 Legal Support

The TIP-RC Project has experienced numerous problems trying to obtain justice for VoT in Sierra Leone, which has been a significant implementation issue for this project. Nearly 2/3 of the TIP-RC respondents stated that the most challenging aspect of working with trafficking victims in Sierra Leone was dealing with the judicial system. Numerous challenges were identified that negatively impact human trafficking related prosecutions and convictions in Sierra Leone, including: (a) the limited understanding of TIP and the Anti-Human Trafficking Law in the SLP and the judiciary; (b) the poor quality of police investigations; (c) the tendency to charge perpetrators with lesser charges; (d) witness tampering by perpetrators; (e) pressure from perpetrators to compromise cases (i.e., settling outside of court via financial compensation); (f)

procedural inefficiencies and frequent court delays; (g) the lack of affordable transportation for victims to attend court proceedings; (h) victims not wanting to testify, especially when perpetrators are family members; and (i) corruption in the legal system.

UNICEF (2005) and Sawadogo (2012) have documented similar problems regarding law enforcement and judicial efforts to combat human trafficking in Africa. Further, the 2016 Trafficking in Person Report (U.S. Department of State, 2016) recommends that the GOSL, "in collaboration with civil society organizations, train police and prosecutors to identify, investigate, and prosecute trafficking cases; and take steps to address procedural delays in trafficking cases, which place undue burden on victims and often result in prosecutors dropping criminal charges against alleged offenders" (p. 332). Data is not available yet for 2016, but in 2015, the FSU identified 46 TIP cases (involving 59 identified child trafficking victims) and 37 cases were referred to residential care facilities (i.e., TIP-RC and other alternative care providers) through the MSWGCA. Even though police investigations were completed on all 46 TIP cases, only 5 cases were charged with human trafficking offenses, which was partially due to the lack of evidence collected from the police investigations. In 2015, no convictions were obtained for human trafficking offenses. Three of the 5 charged cases involved TIP-RC clients.

There are several ways the TIP-RC offers legal support to VoT as an attempt to increase the victims' access to the justice system and promote prosecutions of TIP perpetrators. First, the TIP-RC advocates for the police to conduct appropriate police investigations and then they work with them to facilitate this process. Although the FSU is responsible for protecting women and children in Sierra Leone, including investigating child trafficking cases, they only have three police vehicles for the entire country. This severely limits their ability to perform their responsibilities, including police investigations. Therefore, the TIP-RC provides transportation so that their clients can give police statements and provide sufficient evidence (e.g., victims can show the police the physical location of their exploitation). Second, the TIP-RC links their clients to the state counsel who is prosecuting the case, and they will advocate to the judiciary for appropriate legal proceedings. For instance, when legal cases are not moving forward, the TIP-RC Social Workers or other WHI staff members will talk with the relevant judicial officials to put pressure on them to continue with the prosecution. Third, they drive residential and reintegrated clients to all their court hearings, regardless of the frequency or location in Sierra Leone. In addition, the assigned Social Worker, and usually the assigned Counselor, will attend all court hearings with clients. Also, when WHI's TIP Prevention Program was funded, their staff members or the paralegal from a local VPG would attend court cases that were in their local area in order to provide court monitoring and advocacy. During court proceedings, the TIP-RC Social Workers will advocate for victim protection practices so that victims do not have to testify in open court. Lastly, the TIP-RC Counselors provide pre and post counseling to the clients for all legal events, including when clients provide police statements or attend court proceedings.

Key informants indicated that the legal support provided by the TIP-RC Project helps improve victims' access to the judicial system in several ways. First, the transportation provided for police investigations and court proceedings is important because, as one respondent stated, "parents are not likely to take the victims to the police or court" due financial constraints and a low view of the justice system. In fact, since the TIP-RC reopened in October 2015, all residential clients have made police reports or given police statements, and 22 clients currently

have cases being prosecuted. Second, the victims are more likely to testify in court because of the support provided by the TIP-RC via the pre-court counseling and the advocacy for victim protection practices during court hearings. Third, several respondents stated that cases are less likely to be compromised when victims are in the shelter until their cases are charged in court. For example, since most perpetrators live in the same community as their victims, residential care minimizes safety issues, witness tampering, and pressure to drop cases. Since the TIP-RC reopened, none of their clients' legal cases have been compromised. Also, key informants from two VPGs indicated that although there have been several prosecutions for cases they have identified (including cases involving GBV, child labor, and human trafficking), both VPGs have only had one case each receive a conviction and both of these convictions were for the only cases they referred to the shelter. However, both of these convictions were under the Sexual Offences Act, not the Anti-Human Trafficking Act. Several respondents indicated that it has been easier and more likely for convictions to be obtained for sexual offenses, instead of trafficking-related crimes.

However, the TIP-RC has not been able to develop a successful partnership with legal aid services, which causes them to rely on the state counsel to prosecute their clients' legal cases. All respondents stated that this is very problematic due to the lack of professionalism (e.g., it is not uncommon for the state counsel not to show up to court proceedings), the lack of commitment to advocate for the victims, and their willingness to take bribes from perpetrators. There is a strong belief that having a lawyer on retainer or partnering with a legal aid service provider could help improve the conviction rate. However, all these services, including legal aid services, are very expensive, and WHI has a limited budget to invest in these services. Due to factors outside of the WHI's control in the judicial system, they are wary of using their funding on legal cases that are not likely to go anywhere. Yet, in 2016, a politically well-connected perpetrator of one of the TIP-RC's trafficking clients was convicted under the Sexual Offences Act (due to a technicality in the law, the perpetrator was not charged under the Anti-Human Trafficking Act). This conviction was most likely obtained due to two factors: (a) the TIP-RC temporarily admitted the victim's mother into the shelter due to safety issues and to reduce the likelihood that the case would be compromised; and (b) the TIP-RC partnered with a human rights organization in the local community to advocate for justice in the local media. In short, the TIP-RC has increased its clients' access to the justice system, but it is unlikely to promote convictions of TIP perpetrators without developing stronger partnerships with legal service providers and other human rights groups.

3.2 REFERRAL AND SCREENING PROCEDURES

Unidentified child trafficking victims are most likely to be identified by law enforcement officers, human service providers (e.g., medical providers, social workers, or teachers), or immigration officials (Bump & Duncan, 2003; Hodge, 2014). Often VoT are not identified because government officials and various human service providers lack knowledge about the causes and consequences of TIP, victim identification, and appropriate case management strategies (Bump & Duncan, 2003; Macy & Johns, 2011; Muraya & Fry, 2016; Okech et al., 2011; Sigmon, 2008). However, very little research has been conducted on how to improve victim identification (Macy & Graham, 2012). Although it is strongly recommended that law enforcement officers, immigration officials, and human service providers be trained on

trafficking issues and victim identification (Gozdziak, 2007; Rafferty, 2012; Macy & Johns, 2011; Surtees, 2013), currently there is no evidence that these trainings improve the identification of VoT. For example, an evaluation of an anti-trafficking program in Florida that trained more than 7,000 local law enforcement officers, social service providers, and medical personnel on TIP identification found no increase in TIP-related victim identification after providing these trainings (Potocky, 2011).

3.2.1 TIP-Related Trainings

Still, the 2016 Trafficking in Persons Report recommended that Sierra Leone train local law enforcement officers and government social workers on how to identify VoT in vulnerable populations and how to provide appropriate protective services (U.S. Department of State, 2016). These TIP-related trainings are probably even more essential because the most prominent form of child trafficking in Sierra Leone – forced labor in domestic servitude – can be one of the most difficult types of trafficking to identify (Sigmon, 2008). During the current cost extension of the TIP-RC Project, WHI has trained 42 MSWGCA social workers and 68 FSU police officers as a means to increase victim identification and to improve the appropriate use of the national referral mechanism for TIP cases. Another goal of these trainings was to improve the capacity of the GOSL to combat human trafficking in Sierra Leone. As part of this training process, WHI developed the TIP Assessment Tool, which is a comprehensive, yet simple tool that can be used to identify VoT and gather evidence for police investigations. WHI presented this tool, as well as distributed copies of it, to the TIP National Task Force. They also trained all 68 FSU line managers on how to use the TIP Assessment Tool and encouraged them to train their reporting police officers. In addition, TIP-RC Social Workers have been conducting follow-up visits with the FSU police stations in order to distribute more copies of the tool and review the form with all the FSU police officers. Based on the direct observations for this evaluation, it was clear that the follow-up visits helped increase the police officers' knowledge of TIP and they obtained a better understanding of how to handle suspected TIP cases in the future. However, the TIP-RC Project has not seen an increase in referrals from the FSU since they started using the TIP Assessment Tool.

In addition, the TIP-RC has found that MSWGCA social workers often lack awareness about the legal definition of TIP and the need to provide case management services to VoT. Thus, WHI recently trained 42 MSWGCA social workers, including 3 social workers per district, on: (a) the legal definition of TIP and common issues related to TIP in Sierra Leone; (b) how to provide assistance and case management services to VoT; and (c) how to use the TIP Assessment Tool and the national referral mechanism. A review of the training curriculum indicated that it was comprehensive and appropriate for the targeted audience, while also containing useful discussion questions and experiential activities to spur learning. However, WHI reported that several of the district social workers did not show-up to the trainings, but instead sent representatives. The key informant at the MSWGCA stated that these trainings have improved the capacity of their social workers as evidenced by their increased knowledge about TIP issues from the pre- and post-testing at the trainings. This respondent also stated, "On the ground, the knowledge needs to be implemented, but [the MSWGCA social workers] often do not have the transportation to do the case management, but WHI does. Even though they have knowledge, logistics present a challenge to implementation."

Moreover, since the TIP-RC reopened in October 2015, the TCPS has trained the social workers at the Sierra Leone Alliance (i.e., 5 organizations working with Ebola orphans) on TIP identification and appropriate case management strategies, including referral procedures for VoT. Other organizations that have been trained under previous TIP-RC grants or WHI's TIP Prevention Program include: WMF (i.e., CBO working in Kroo Bay slum in Freetown), Solthis (i.e., NGO providing HIV treatment), Goal (i.e., NGO working with street children), SHADE (i.e., CBO working on reducing FGM), Medair (i.e., emergency medical response company), Save the Children, World Vision, Wesleyan Church of Sierra Leone, police officers (including developing a TIP training manual for the police academy), and the Immigration Department. However, WHI has noted that information from these trainings do not usually "trickle down to lower levels" because in the Sierra Leonean value system, knowledge is considered personal property and is not commonly shared with others. As one WHI respondent stated, "If there are no outside trainings, it won't trickle down" to other employees in an organization.

3.2.2 Referral Procedures

The end goal of these TIP-related trainings is to improve victim identification and appropriate referrals of VoT to victim assistance programs. In conjunction with the trainings provided by WHI, the TIP National Task Force has also instituted a national referral mechanism for VoT in order to improve the systematic identification and referral of trafficking victims in Sierra Leone. The TIP national referral mechanism follows the national referral protocol for GBV cases, which requires: (a) giving victims immediate medical care, if necessary; (b) reporting cases to the FSU; (c) the FSU then informs the MSWGCA; and (d) the MSWGCA is responsible for referrals for (or the direct provision of) psychosocial care. Because the MSWGCA is dependent on WHI for the provision of victim protection services for minors, and the TIP-RC is the only specialized trafficking aftercare program in Sierra Leone, all referrals for the psychosocial care for minors should be made to the TIP-RC.

According to 2013 TIP-RC Evaluation (Barnett, 2013), referral sources for the TIP-RC were widespread, yet these sources often struggled with identifying appropriate cases to refer. From 2012 until the shelter closed in July 2015, there were 17 different referral sources. The three largest referral sources during this time period were the SLP (29%), MSWGCA (23%), and WHI/VPG (11%). Table 6 lists the referral sources for all clients, including residential and non-residential clients, since October 2015. The sharp increase in referrals from the MSWGCA from 23% (before the shelter closed) to almost 72% (since the shelter reopened) provides evidence that the national referral mechanism is being followed more consistently. Moreover, from 2012 until July 2015, only 53% of referrals sources were part of the GOSL (including MSWGCA and SLP), whereas since October 2015, 84.6% of referrals sources were part of the GOSL. This may indicate an improvement in the government's ability to appropriately identify and refer VoT to the TIP-RC.

Although there have been lapses in following the national referral mechanism, key informants at the TIP-RC believe that the referral sources have improved in their ability to accurately identify VoT and then refer them to the TIP-RC. They attribute this improvement to WHI's TIP-related trainings and the on-going collaboration with partner organizations. As one respondent stated, "they think of WHI when they see trafficking." All key informants at partner organizations clearly identified the appropriate referral procedures for the TIP-RC and they appreciated how

easy it was to refer cases. However, not all of these key informants could accurately describe how they would identify a trafficking victim, although the organizations that have received TIP-related trainings from WHI were the most accurate. The TIP-RC Social Workers reported that referral sources, especially the police, still struggle with differentiating human trafficking from child labor, child abuse, or GBV. Furthermore, there was some confusion with key informants at partner organizations about whether the TIP-RC still admitted victims of GBV. Most partner organizations were unaware that the shelter had changed its admission criteria so that only VoT are now being admitted for residential care.

All key informants at partner organizations clearly stated that there were no other reliable social services available in Sierra Leone to address the specialized needs of trafficking victims. Multiple respondents indicated that it would be very difficult for them if the TIP-RC closed. The MSWGCA key informant stated that they would be unable to fund or adequately staff a shelter for VoT in Sierra Leone, even though this Ministry is technically responsible for the provision of psychosocial care for identified victims. According to another respondent, "There are few shelters, but they all have their own mandate and we would have to convince them to take the cases. But they do not provide specialized care. It would be very difficult if the [TIP-RC] shelter did not exist. Sometimes the children have to sleep in the police station or return home without a risk assessment, which exposes the children to other abuses." As a result, several key informants were highly concerned about the sustainability of the TIP-RC Project. One key informant reported that she even wrote a letter to the CEO of WHI, asking him to continue funding the TIP-RC Project because they depended on their services to help trafficking victims.

Table 6

Referral Sources for TIP-RC Clients Since October 2015

Referral Sources	*N*	Percentage
MSWGCA	28	71.8%
Sierra Leone Police [a]	4	10.3%
WMF	4	10.3%
VPG	2	5.1%
AWC	1	2.6%
Cap Anamur	1	2.6%
Immigration Department	1	2.6%
Private Person	1	2.6%

Note. Total percentage is greater than 100% due to some cases having more than one referral source.
[a] includes Family Support Unit (FSU) and Transnational Organized Crime Unit (TOCU)

3.2.3 Screening Procedures

After VoT are identified and referred to the TIP-RC, they need to be screened via an intake assessment in order to determine their appropriateness for admission to residential care and to determine their basic needs. Based on a review of the sex trafficking victim identification literature, it is recommended that screening questions be child-friendly and assess information about the victim's safety, employment and/or education, living situation, and travel or immigration history (Macy & Graham, 2012). The following recommendations were also made about how to screen potential VoT:

> . . . (a) question a potential victim when he or she is alone; (b) use indirect rather than direct questions, excluding words such as ''coercion,'' ''force,'' and ''trafficking'' (e.g., I would be interested to hear . . . or Can you tell me . . .); (c) clearly explain the service provider role to potential victims; (d) clearly explain confidentiality policies and how the information the victim provides will be used; (e) focus on the potential victim's safety and needs; and (f) conduct interviews and provide services with cultural and linguistic competence. (Macy & Graham, 2012, p. 70)

The screening process utilized by the TIP-RC Project follows the above guidelines as well as the practices recommended by the International Organization for Migration (IOM) for the screening of VoT (IOM, 2007). The TIP-RC Social Workers are the point of first contact for referrals, and they obtain preliminary information from referral sources to determine the appropriateness of the cases before conducting an in-person assessment. Several of the key informants from referral sources stated that the TIP-RC Social Workers come either the same day or the next business day to screen the referred cases. One respondent stated, "Our staff members know the Social Workers personally. The Social Workers are very good and they work very well with the clients." This evaluator happened to interview key informants from two different partner organizations on the same day that both organizations had referred cases to the TIP-RC. It was clear from these unplanned observations that these organizations were happy with the Social Workers' professionalism, collegiality, and promptness.

During the screening process, the TIP-RC Social Workers interview referred individuals privately, using the TIP Assessment Tool to determine if these individuals are human trafficking victims. The Social Workers also ask questions from the intake assessment to collect additional information about the referred cases, including information about their family, current living situation, educational history, and traumatic experiences. They will also ask questions to try to figure out why the victims were targeted (e.g., "What was life like before you came to your current living situation?") and to assess their current vulnerability factors (e.g., "How big is your family? And what did your family due for a living? Did you go to school and was there a school in your community?"). The TIP-RC Social Workers also reported that they observe the physical and mental condition of the referred cases during the screening process.

After completing the in-person assessment, the Social Workers will discuss the cases with the TCPS or the Shelter Manager before admitting any cases that meet the admission criteria for residential care. The MSWGCA is also contacted to get verbal approval for any admissions. The Social Workers will then transport the cases to the shelter, while the TIP-RC obtains legal guardianship of minors from the MSWGCA within 24 hours. If the shelter is currently full or if the referred cases do not meet residential admission criteria, the Social Workers provide

immediate case management assistance, such as arranging urgent medical care, referring the cases to another appropriate shelter, or mediating family conflicts to help stabilize the individual's living situation. One of the biggest challenges encountered by the TIP-RC Social Workers when screening referrals involves identifying cases that do not fit the definition of TIP, but who are very vulnerable and need emergency housing. In these instances, they try to meet their most pressing needs through the provision of basic case management services. Overall, the TIP-RC Project has a well-developed screening process, which contributes to the accurate identification of VoT and begins the process of providing them with appropriate victim assistance services, without disregarding the needs of other vulnerable populations.

3.3 REINTEGRATION SUPPORT SERVICES

Reintegration is the process of re-entry into normal community life following a trafficking experience (Muco, 2013; Surtees, 2013). "It includes settlement in a safe and secure environment, access to a reasonable standard of living, and mental and physical well-being, opportunities for personal, social and economic development, as well as access to social and emotional support" (Surtees, 2013, p. 4). Reintegration support services can include a range of services, but they should focus on empowering VoT (Surtees, 2013). A systematic analysis of the aftercare service delivery literature for child sex trafficking victims found that the recommended reintegration services include: (a) client assessments to determine reintegration readiness; (b) community assessments to determine appropriate reintegration placements based on the best interest of the child; and (c) post-reintegration follow-up to monitor safety factors and the well-being of the trafficking victim (Muraya & Fry, 2016). This section will discuss in what ways the TIP-RC Project is in compliance with these recommended reintegration support services, whereas the outcomes of these services will be discussed in Section 3.6 of this report.

3.3.1 Assessment and Preparation – Clients

Client assessments need to ascertain whether VoT have adequate life skills and confidence to function in normal community life (Muraya & Fry, 2016). Reintegration plans should also take into consideration clients' preferences and concerns (Arensen, Bunn, & Knight, 2004; Surtees, 2013). In the TIP-RC service delivery model, clients are not formally assessed to determine if they are ready for reintegration. Instead, the Counselors determine if clients are ready for reintegration by: (a) clinically observing a reduction in their mental health symptoms as well as seeing an increase in prosocial behaviors and self-confidence; (b) clinically observing appropriate bonding with their family members via phone calls and the family bonding visit; and (c) asking clients about their preferences, readiness, and concerns about reintegration. One Counselor reported that it is a good sign when clients state that they are ready to leave the shelter because most of them know that they will experience more challenging circumstances in normal community life in Sierra Leone than they do in the shelter (e.g., regular physical work in the village, not enough food, little time to play, less emotional support from caregivers, and possible exploitative situations). Sometimes clients do not want to be reintegrated due to these factors, which the Counselors handle by helping them process their concerns and then helping them engage in problem solving. Before reintegration plans are made, the Counselors discuss all the above assessment data in the case management team meetings so that reintegration decisions are not made until clients show readiness for reintegration.

One recommendation regarding preparing children in residential care for reintegration involves facilitating adequate family bonding via family visits and communication before reintegration (Arensen et al., 2004; Reimer et al., 2007; Surtees, 2013). Immediately after clients are admitted to the TIP-RC, the Social Workers begin family tracing efforts nationwide to find relevant family members. This process frequently involves collaboration with other organizations (e.g., Save the Child, VPGs, and MSWGCA) that can assist with finding family members. Once family members are found, the Social Workers arrange for them to come to Freetown to conduct a family bonding visit with the client in WHI's main office. Both the assigned Social Worker and Counselor attend these meetings in order to support the client while assessing the family bonds and the family's response to the client's exploitation. The clinical staff members at the TIP-RC agreed that the family bonding visits provided useful assessment data about possible family factors that could affect reintegration, but they generally did not think these visits were sufficient in helping clients bond with family members, especially if they had been separated for a long time. Several respondents indicated that doing an overnight home visit with the family would better prepare clients for family and community relationships after reintegration. However, due to staffing and funding limitations, the TIP-RC can only arrange one family bonding visit in Freetown, but they encourage regular telephone communication between clients and family members.

It is also recommended that residential clients need to be prepared for reintegration by discussing transition and termination issues in counseling once reintegration plans have been developed (Reimer et al., 2007). According to the TIP-RC Counselors, they inform residential clients at admission that the shelter is a temporary place to stay in order to recover. For at least 2-3 counseling sessions before reintegration, the Counselors try to prepare clients for reintegration (e.g., what to expect during the reunification process and what is expected of them in normal community life) and help improve their problem solving in regards to common post-reintegration problems (e.g., "You are likely to face this. How are you going to handle it?"). However, very little time is spent processing termination issues in counseling, although clients are able to say good-bye to the other clients and staff members at the shelter during a culturally appropriate good-bye party hosted by the House Parents.

Several respondents at the TIP-RC reported that the residential clients could be better prepared for reintegration if the shelter utilized more culturally appropriate disciplinary practices. Although these staff members acknowledged the benefits of using the shelter's relational approach to handling externalizing problems in the clients (e.g., verbal or physical aggression), they believe the clients also need some natural consequences for their problem behaviors. One TIP-RC staff member stated, "When they are reintegrated, they have a hard time adjusting and being accepted in their communities if they are not used to consequences for poor behavior. They need to learn boundaries, otherwise they will be rejected. This will put them at risk to be re-trafficked." Still, key informants from partner organizations felt that the TIP-RC did an adequate job of preparing the clients that were reintegrated in their communities.

3.3.2 Assessment and Preparation – Families and Communities

Several authors have recommended that both families and communities need to be assessed for protective factors and risk factors (e.g., stigma and presences of perpetrators) before making reintegration plans (International Labor Organization, 2006; Reimer et al., 2007; Surtees, 2013).

In order to prevent future re-victimization of the reintegrated trafficking survivors, risk factors in the family and community need to be reduced. This could include using family mediation to reduce possible family problems that could interfere with reintegration, and/or providing economic assistance to reduce economic risk factors in the family (Surtees, 2013). When risk factors cannot be mitigated in the family-of-origin or community, alternative reintegration plans should be developed (Surtees, 2013).

Before reintegration plans are made, the TIP-RC Social Workers complete a thorough assessment of the family and community. They spend several hours in the family's home and community, observing the environment and interviewing both family members and several community stakeholders (e.g., local chief, teachers, and any relevant community organizations). As part of this assessment, they will determine the protective factors and risk factors related to the family, including their adaptive functioning, relational functioning, parenting ability, and their beliefs about the client and the client's exploitation. The Social Workers will also determine the protective factors and risk factors related to the community, including safety factors (e.g., "Are they aware of human trafficking? Is exploitation common in the community?"), the availability of community resource, and the availability of supportive community members.

The case management team (i.e., Shelter Manager, TCPS, Social Workers, and Counselors) then discusses the family and community assessment data, as well as the client assessment data, to make reintegration plans that are in the best interest of the clients. However, sometimes the family-of-origin refuses guardianship of the client, or the client refuses to return to the family-of-origin, or the case management team determines the family is not an appropriate reintegration environment for the client. Then they attempt to find appropriate extended family members who are willing to raise the client. If no appropriate and willing family members can be found, the TIP-RC Social Workers will arrange long-term residential care at an orphanage. Over the course of the project, only 3 of the 89 reintegrated clients have been placed in long-term residential care, evidencing the TIP-RC's commitment to utilize family care as often as possible in their reintegration plans.

The TIP-RC Social Workers will then attempt to reduce risk factors in the reintegration environment. For example, they will try to mediate family conflicts (e.g., conflict between two wives in a polygamous family) that could hinder the success of the reintegration process. Also, they will help family members find new housing when the perpetrators live nearby or community stigma is present. Also, the Social Workers will attempt to identify people in the community that the parents trust and then recruit them to support the family. According to one of the Social Workers, "This is key because it helps stabilize the child in the community. It helps support the family and it increases the child's acceptance in the community." Additionally, research findings indicate that post-reintegration caregivers should be equipped with parenting skills and psychoeducation about trauma before reintegration (Borisova, Betancourt, & Willett, 2013; Reimer et al., 2007). The TIP-RC Social Workers reported that they provide psychoeducation to post-reintegration caregivers on the following topics before and after reintegration: (a) TIP-related issues, (b) healthy parenting practices, (c) child protection practices, and (d) caregiving strategies for traumatized individuals.

Also, the TIP-RC Social Workers provide reintegration support packages for the post-reintegration caregivers as a means to reduce economic risk factors in these families. The reintegration support packages include paying the reintegrated client's initial school fees, providing sufficient clothing and school supplies for the reintegrated client, and providing an income generating project for the family based on the family's recommendation (e.g., buying them items to sell via petty trading or giving them seeds to use in agriculture). All respondents indicated that the reintegration support packages were only sufficient in meeting the economic needs of the majority of the families for 3-6 months post-reintegration. In particular, these packages are not large enough to fund strong income generating projects, after paying for school fees and clothing, especially since Sierra Leone is currently experiencing high rates of inflation. Also, most family members lack training on how to run a business; thus, most are not able to generate a sustainable income from their projects. For example, the key informants from the VPGs did not realize that the TIP-RC provided income generating projects because both of the post-reintegration caregivers in their communities consumed the items provided, instead of selling them via petty trading. They reported being worried about the well-being of these reintegrated clients due to their families' financial problems and inability to pay their school fees. Moreover, the TIP-RC's reintegration support packages are similar to WHI's practices at their trafficking victim assistance program in Cambodia. A program evaluation of the Cambodian project reported,

> Family income generation does not appear making a significant impact in practice. Families are not properly equipped to be successful with the material support from the project. Additional support in business practices is required which is beyond the scope of project staff. (Simcox & Marshall, 2011, p. 19)

The findings from this evaluation concur with the above conclusions. Furthermore, studies have found that post-reintegration economic problems in families can potentially cause additional emotional and relational stress within these families, negatively affecting the reintegration process (Brunovski & Surtees, 2012; Surtees, 2013). Thus, the problems involving the TIP-RC's reintegration support packages could possibly undermine the program goals.

When TIP-RC clients are reunified with their post-reintegration caregivers, the TIP-RC Social Workers and Counselors are present to support the clients as well as to prepare the family and community for reintegration. They also invite the local chief and other key community stakeholders (e.g., teachers or religious leaders) to be present as well as local MSWGCA field workers, VPG members, or WMF staff, if they are operating in the local community. During the reunification process, TIP-RC staff members provide further education to the family as well the community stakeholders about human trafficking and child protection practices. Key informants at the TIP-RC, WMF, and the VPGs stated that this is a key factor for successful reintegrations in the Sierra Leone context because the community stakeholders, especially the local chief, can use their authority to "reduce stigma, increase the survivor's confidence, and increase their acceptance by the community." As a result of this community education on TIP-related issues during the reunification process, one local chief even levied a fine against each family member who sent their children away, which sent a clear message in the community that human trafficking would not be tolerated.

3.3.3 Monitoring Practices

After reintegration, regular monitoring of reintegrated clients is necessary to ensure successful reintegration outcomes because additional support and interventions can be provided when problems are discovered (Arensen et al., 2004; Jayagupta, 2009; Surtees, 2013; Trees, Thahn, & Hung, 2012). The IOM (2007) recommends that reintegrated VoT should be monitored monthly for the first 3 months and then on a quarterly basis for no longer than 12 months due to the intrusive and stressful nature of these monitoring visits. However, for minors, monitoring can extend past 12 months due to more complex and long-term needs. Case monitoring is labor intensive work, requiring adequate staffing and resources (e.g., due to transportation and telephone costs) to have regular contact with reintegrated clients (Surtees, 2013). Trained partner organizations in the local reintegration community can also provide help with implementing reintegration plans and assisting with follow-up (IOM, 2007).

At the beginning of the TIP-RC Project, the Counselors and Social Workers would conduct community-based follow-up visits with reintegrated clients on a quarterly basis for the first year after reintegration. However, the TIP-RC has not been able to continue the frequency of the community-based follow-up visits given that their current staffing levels have not kept up with their caseloads. Now they complete approximately 2 community-based follow-up visits during the first year after reintegration, while utilizing more phone calls to monitor the reintegrated clients. During these community-based visits, the clinical staff members will talk with the reintegrated clients, caregivers, and key community stakeholders, especially the local chief and the teacher, to assess the reintegration process and then provide necessary interventions or support. Between these follow-up visits, the Social Workers often call community stakeholders and the Counselors regularly call reintegrated clients to check-up on them. Also, to minimize travel costs, they try to complete several follow-up visits or conduct other support services while in a remote region of Sierra Leone, which makes the timing of the follow-up visits inconsistent.

To help supplement their monitoring practices, the TIP-RC Project uses implementing partners in the local reintegration community to assist with follow-up. WHI believes that this improves their reintegration outcomes. WMF and local VPGs have been particularly helpful in monitoring reintegrated survivors and calling the TIP-RC Social Workers when there are problems. WMF will also enroll reintegrated clients that live in the Kroo Bay slum into their mentoring program and encourage them to participate in weekly community activities provided by their organization. Additionally, the VPGs advocate for the reintegrated clients' needs to both family members and community members, which helps reduces stigma. WHI respondents reported that the local MSWGCA field workers should also follow-up with reintegrated cases, but often they are not available (e.g., there are not enough field workers, they are not working at their assigned post, or they do not have transportation to visit cases) or they do not understand the need for case management for VoT.

TIP-RC will generally provide reintegration support services for at least 12 months after reintegration, but decisions to close cases are based on assessment data from their monitoring practices. They will continue to monitor cases past 12 months if they are not stable and could benefit from additional support services. One key informant stated that it is very important that reintegrated cases are followed for at least one year because there are many Sierra Leonean cultural beliefs and practices that make it difficult for reintegration to go smoothly, including

high rates of exploitation in normal community life and the low status of women and children in Sierra Leone society. The most common post-reintegration problems that have been identified from the TIP-RC's monitoring practices include: (a) economic insecurity due to the limitations of the income generating projects; (b) food insecurity; (c) the inability to pay additional school fees; and (d) complaints about the reintegrated clients' externalizing problems (i.e., hostility) or use of self-protection skills (e.g., advocating for her needs). The TIP-RC has little recourse to intervene for the first three problems once the reintegration support packages have been used up, but they do provide psychoeducation and support to caregivers to help address problems related to the reintegrated clients' behaviors. Overall, WHI key informants think their current monitoring practices are adequate, but it could be strengthened if they had additional clinical staff members. This would allow them to complete more follow-up visits and provide more case management support when problems are identified.

3.4 STAFF CAPACITY OUTCOMES

One of the key components of effective trafficking victim assistance programs is the professional capacity of the staff members. Comprehensive aftercare services are labor intensive, requiring "highly skilled, sensitive, ethical and committed professionals to work with trafficked persons over the long term" (Surtees, 2013, p. 24; also Johnson, 2012; Muraya & Fry, 2016). In addition, caregivers in residential care facilities for child trafficking victims need to be gender appropriate and child friendly (Muraya & Fry, 2016). However, low resourced countries generally lack professionally trained and qualified service providers; therefore, program resources must be invested in training and supervising staff members to develop sufficiently competent service providers (Newnham et al., 2015; Surtees, 2013; Trees et al., 2012). Common issues that have been reported in international aftercare facilities with insufficiently developed staff capacity include: (a) not understanding the effects of trauma; (b) not having child-centered priorities; (c) not respecting confidentiality or other human rights; (d) poorly managing client crises; and (e) perpetuating community stigma via discrimination and insensitive treatment (Aborisade & Aderinto, 2008; Arensen et al., 2004; Surtees, 2013). However, "service providers without professional accreditation can be trained in working with trafficked persons in ways that support their psychosocial well-being and recovery" (Surtees, 2013, p. 134). In fact, Newnham et al. (2015) trained and supervised a team of Sierra Leonean mental health interventionists (including 3 current clinical staff members of the TIP-RC) to successfully implement a skills-focused group intervention to distressed war-affected youth in Sierra Leone, which resulted in significant improvements across a broad range of mental health outcomes for the participants. In countries that lack a well-developed social service field, as is the case in Sierra Leone, building staff capacity is essential for the provision of quality of care and is probably linked to client outcomes (Surtees, 2013).

As was discussed in Section 2.2.7, one of the most significant implementation issues faced during this project has been the inability of WHI to find qualified staff members in Sierra Leone. They have addressed this issue by continuously employing an expatriate staff member with clinical credentials to fill the TCPS position, which has allowed them to provide on-going trainings and clinical supervision to the TIP-RC staff members. To determine how effective the TIP-RC has been in building staff capacity, the following indicators were used to assess staff capacity outcomes: (a) high level of trauma-informed care; (b) effective development and

implementation of both treatment plans and reintegration plans; (c) regular use of data-based decision making; and (d) regular use of self-care practices by staff members. These indicators will be discussed in greater detail below.

3.4.1 Trauma-Informed Care

Providing trauma-informed care is a strongly recommended service delivery practice for trafficking victim assistance programs (Clawson et al., 2008; Johnson, 2012; Macy & Johns, 2011; Muraya & Fry, 2016; Zimmerman & Borland, 2009). "This involves all caregivers in the system of care understanding the effects of trauma on individuals, while focusing on the empowerment and recovery of trauma survivors in a collaborative manner" (Barnett, 2013, p. 21). The following are key components of trauma-informed care: (a) staff members recognize how trauma affects clients, including the development of coping strategies; (b) service delivery focuses on helping clients recovery from trauma, while minimizing risks of re-traumatization; (c) staff members utilize a relational collaborative approach, including maximizing clients' choices and control during the recovery process; and (d) service delivery uses an empowerment philosophy that recognizes clients' strengths and builds their resiliency (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005).

Based on the semi-structured interviews with TIP-RC staff members and the direct observations (see Table 7 for a summary of the findings for the direct observations), there is substantial evidence that the staff members have generally developed a high level of trauma informed care. Overall, the staff members were able to identify the common effects of trauma and trauma-related coping strategies. All staff members showed a strong commitment to their clients' recovery. Moreover, there was evidence that the staff members prioritize the physical and psychological safety of their clients. For example, the TIP-RC Nurse reported that she monitors the language used by medical providers at partner organizations so that they do not inadvertently re-traumatize the TIP-RC clients. As indicated in Table 7, one of the greatest strengths of the TIP-RC staff is their ability to create effective therapeutic relationships with the clients, which are characterized by empathy, respect, unconditional positive regard, and professional boundaries. According to one House Parent, "We were trained to love them like our own children. When we start talking to them we have passion for them like our own children. It's a child-parent relationship." The staff members also obtain informed consent from the clients and they try to give them control over their recovery process within certain limits (e.g., there is less choice given about meeting essential medical needs). In addition, all caregivers were able to describe how they assess their clients' strengths and improve their resiliency within the context of their particular jobs. For example, the Counselors plan the weekly life skills training based on the current needs of the residential clients, whereas the Activities Coordinator attempts to empower the clientele through his planned activities, including helping them develop communication skills, interpersonal skills, and self-esteem. Moreover, the clinical staff members appeared particularly strong in their ability to identify strengths in both the clients and their families.

Multiple respondents stated that about 60% of the residential clients show symptoms of trauma, which they assess in every client at admission using the TIP Assessment Tool (i.e., to assess various forms of exploitation) and the CCAT (i.e., to assess trauma symptoms). In general, staff members stated that the most common emotional problems (i.e., anger and sadness) and

behavioral problems (i.e., aggression, abusive language, and social withdrawal) evidenced by the clientele were due to their past traumatic experiences. As a means to address these trauma-related emotional and behavioral problems, the trauma-informed care literature recommends that all clients have an individualized safety or crisis management plan, which should include identified triggers and preferred de-escalation strategies based on client feedback (Elliot et al., 2005). Yet, TIP-RC staff members only develop an individualized safety or crisis management plan for residential clients on an ad hoc basis and without significant client feedback. Instead, staff members generally manage dysregulated clients by making sure a staff member is present, removing the other clients, validating the client's emotions, encouraging the client to calm down, and conducting a physical hold if the client is violent. Although they have found this relational approach to work well for clients with internalizing problems (e.g., depression and anxiety), it is less effective for clients with externalizing problems (e.g., verbal and physical aggression). There was also evidence that the TIP-RC caregivers do not sufficiently monitor clients with externalizing problems in order to prevent emotional and behavioral dysregulation, nor do they utilize individualized behavior modification programs in the residential milieu as an intervention strategy for the most highly symptomatic clients.

Still, staff members are definitely counter-cultural in how they perceive and address client situations. For example, common Sierra Leonean child care practices generally involve disregarding children's emotional needs, and it is generally acceptable to physically abuse children when they exhibit behavioral problems. Moreover, people with mental health problems, including posttraumatic stress disorder (PTSD), are commonly stigmatized as witches or demon possessed in Sierra Leone (Barnett, 2013). However, the staff members do not show any evidence of exhibiting these common cultural practices. Instead, the majority of the TIP-RC staff members stated that they are highly appreciative of their work-related trainings because it has improved their ability to be better parents to their own children, indicating that they have internalized the caregiver training provided to them.

Table 7

Summary of the Direct Observations Recording Sheet for the Observed Shelter Activities

Observed Characteristics	*M*	*SD*
1. Physical environment attuned to safety, calming, and de-escalation	4.5	0.5
2. Staff executed their roles and duties responsibly and professionally	4.8	0.4
3. Staff used a strengths-based, positive approach in all their interactions	4.6	0.5
4. Staff demonstrated empathy, respect, and unconditional positive regard	5.0	0.0
5. Staff had a rapport or therapeutic relationship with participants	5.0	0.0
6. Staff modeled healthy relationships	4.4	0.5
7. Staff demonstrated effective behavioral management skills	4.6	0.9
8. Staff demonstrated effective emotional management skills	4.7	0.6
9. Participants willingly participated and engaged in the activities	5.0	0.0
10. Staff functioned as a collaborative and supportive team	4.6	0.5

Note. Ratings are based on a Likert scale from 1 to 5, with 1 indicating "not at all" and 5 indicating "all the time." The following observed shelter activities were rated: one meal, one life skills training session, one activity session, one vocational session, one educational session, and one first aid arts session.

3.4.2 Treatment Plans and Reintegration Plans

The aftercare service delivery literature recommends that all VoT receive a comprehensive needs assessment, including an assessment of physical health, mental health, and psychosocial needs, shortly after admission to victim assistance programs (Abas et al., 2013; Macy & Johns, 2011; Muraya & Fry, 2016; Reimer et al. 2007; Surtees, 2013). "It was advised that psychosocial care should begin as soon as possible after the needs assessment, following an individualized treatment plan that is formulated with the input of the child" (Muraya & Fry, 2016, p. 215). Although the service delivery model should be based on trauma-informed care, evidence-based therapeutic approaches should be used to treat specific mental health problems (Williamson et al., 2010). Because there is almost no evidence-based research on the treatment of human trafficking victims, Williamson et al. recommends that victim assistance programs for child trafficking victims should follow the best practices for treating sexually abused children, which is cognitive-behavioral therapy. Both Abas at al. (2013) and Johnson (2012) recommend using trauma-focused cognitive-behavioral therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006) to treat trauma-related symptoms in VoT. The aftercare service delivery literature also recommends that individualized reintegration plans should be based on a comprehensive assessment of the client, family, and community (International Labor Organization, 2006; Muraya & Fry, 2016; Reimer et al., 2007; Surtees, 2013). Moreover, these reintegration plans

should attempt to mitigate the identified risk factors, while also providing ways to adjust the plans based on post-reintegration monitoring activities (IOM, 2007; Surtees, 2013).

The chart review of 8 randomly chosen case files (5 reintegrated clients and 3 residential clients) indicated significant problems regarding the TIP-RC's record keeping practices. All reviewed case files were rated in the Needs Development category for documentation standards on the chart review rubric (see Annex 7 for a copy of the rubric). The reviewed case files contained between 23% and 77% of the required documentation as per WHI policy, indicating that the quality of the documentation had declined since the 2013 TIP-RC Evaluation (Barnett, 2013). It is clear that clinical staff members are not following WHI's documentation policies and they are not being held sufficiently accountable by administration for their poor documentation practices. The TCPS currently performs a chart review audit on a yearly basis, but does not apply any consequences as a result of this audit. Several clinical staff members stated that they do not have enough time to complete their documentation and this is one of the most stressful parts of their jobs. Part of the problems with documentation are related to the insufficient staffing levels for the Social Workers and Counselors, which have resulted in large case loads and the need to prioritize their time spent on service provision instead of documentation. This is exacerbated by the time spent traveling around the country to provide appropriate reintegration support services to the clientele. Some of the clinical staff members stated that they do not want to complete their documentation while in the field, so instead they take notes in a notebook. However, they do not always have time to transfer the information to the case files when they are back in the office. As a result, the TIP-RC's current record keeping practices do not comply with WHI policy and they are below acceptable professional standards for countries with a well-developed social service field.

Due to the poor documentation, the ratings for the chart reviews were confounded by missing documentation, which prevented an accurate assessment of clinical skills when all 8 case files were included in the analysis. Therefore, only the case files that were generally in compliance with WHI policy (i.e., 2 reintegrated clients and 2 residential clients) were used to determine the capacity of the TIP-RC staff members in developing and implementing treatment plans and reintegration plans (see Table 8 and 9). However, these should be considered preliminary findings due to the small sample size of case files reviewed.

As indicated in Table 8, all treatment plan elements were evaluated at a competent level or higher in their implementation. The Counselors were particularly strong in their ability to: (a) use individualized skills-oriented interventions; (b) indicate the clients' response to interventions; and (c) implement follow-up strategies with clients. The Counselors need to improve in their ability to write treatment goals in observable and measurable terms. Furthermore, their trauma-specific interventions were primarily limited to providing psychoeducation on trauma and building coping skills. This is in line with Herman's (1997) Stage 1 trauma interventions (i.e., stabilizing symptoms and building coping skills), which are necessary before implementing Stage 2 trauma-focused interventions (i.e., exposure-based interventions and cognitive restructuring). Still, there is room for the Counselors to develop additional trauma-specific interventions, especially in regards to the use of TF-CBT.

As indicated in Table 9, the majority of the reintegration plan elements (7 out of 10) were evaluated at a competent level or higher in their implementation. The Social Workers were particularly strong in their ability to: (a) assess and prepare both families and communities for reintegration; (b) clearly identify protective factors and risk factors for reintegration; and (c) develop reintegration plans that addressed these factors and were based on the best interest of the client. For the reintegration plan elements that were below competent levels (i.e., client assessments, family bonding sessions, and follow-up interventions for reintergrated clients), their lower ratings may be partially related to the lack of appropriate documentation. However, clinical staff members indicated that they were not consistently utilizing the CCAT to determine client readiness for reintegration, and they stated that the number of family bonding sessions typically offered were not sufficient to prepare clients and families for reintegration. Also, clinical staff members reported that time constraints and funding limitations negatively impacted their ability to appropriately follow-up with reintegrated clients. Therefore, some of the deficits related to the implementation of reintegrations plans were likely caused by funding and staffing limitations in the program model, instead of the professional ability of the clinical staff members.

Table 8

Treatment Plan Development and Implementation Results from Chart Review (n=3)

Treatment Plan Elements	*M*	*SD*	Classification Level [a]
Strengths & challenges identified	2.7	0.6	Substantially Developed
Treatment goals linked to strengths & challenges	2.0	0.0	Competent
Interventions linked to treatment goals	2.3	0.6	Substantially Developed
Interventions included trauma-specific practices	2.0	0.0	Competent
Interventions included skill development strategies	3.0	0.0	Outstanding
Interventions reflected individual differences	2.3	0.6	Substantially Developed
Implementation of interventions documented	3.0	0.0	Outstanding
Implementation of intervention follow-up	3.0	0.0	Outstanding
Treatment goal progress documented	2.7	0.6	Substantially Developed

Note. The above table only includes case files from the chart review that were generally in compliance with documentation policies. Ratings are based on the following chart review rating scale: 1 = Needs Development, 2 = Competent, and 3 = Outstanding.
[a] Classification level of clinical skills is based on the following: Needs Development (*M* = 1.0), Threshold Development (*M* = 1.1-1.9), Competent (*M* = 2.0), Substantially Developed (*M* = 2.1-2.9), and Outstanding (*M* = 3.0).

Table 9

Reintegration Plan Development and Implementation Results from Chart Review (n=2)

Reintegration Plan Elements	*M*	*SD*	Classification Level [a]
Client assessment for reintegration readiness	1.0	0.0	Needs Development
Family assessment for reintegration readiness	3.0	0.0	Outstanding
Community assessment for reintegration readiness	3.0	0.0	Outstanding
Protective & risk factors identified/mitigated	3.0	0.0	Outstanding
Reintegration plan based on client's best interest	3.0	0.0	Outstanding
Family bonding occurred before reintegration	1.5	0.7	Threshold Development
Client prepared for reintegration	2.0	1.4	Competent
Family & community prepared for reintegration	3.0	0.0	Outstanding
Regular monitoring of reintegrated client	2.5	0.7	Substantially Developed
Monitoring resulted in follow-up interventions	1.0	0.0	Needs Development

Note. The above table only includes case files from the chart review that were generally in compliance with documentation policies. Ratings are based on the following chart review rating scale: 1 = Needs Development, 2 = Competent, 3 = Outstanding.
[a] Classification level of clinical skills is based on the following: Needs Development (*M* = 1.0), Threshold Development (*M* = 1.1-1.9), Competent (*M* = 2.0), Substantially Developed (*M* = 2.1-2.9), and Outstanding (*M* = 3.0).

3.4.3 Data-Based Decision Making

Data-based decision making involves collecting and analyzing various forms of data to inform decision making about interventions and programs (Poynton & Carey, 2006). This data should be used to identify problems as well as to monitor intervention effectiveness at both an individual and programmatic level. In general, data-based decision making should involve: (a) identifying problems or areas in need of attention based on systematically collected data; (b) developing an intervention plan to address the identified problems using evidence-based practices; (c) implementing the intervention plan while monitoring progress (using indirect and direct data) and modifying the intervention plan to address any implementation issues; (d) assessing the outcome of the intervention plan based on data; and (e) sharing results with stakeholders as well as modifying and improving future intervention plans based on these results. The overall goal of data-based decision making is an improved standard of care by conducting more effective interventions and programs.

The TIP-RC Project evidences some areas of data-based decision making, although they are not fully utilizing the data they collect to monitor and improve their interventions. In general, the TIP-RC shows real strength in its ability to assess client needs based on systematically collected

data, and then develop intervention plans based on the identified needs. For example, the Counselors use data collected from the CCAT as well as their clinical observations to develop treatment plans. Both Counselors stated that the CCAT is particularly helpful in providing a comprehensive overview of their clients' needs, including providing information that is unobtainable from clinical observations. The CCAT also helps them have a better sense of what areas to focus on during treatment. As a result of this, they believe that the treatment they provide is more focused and efficient.

However, when it comes to monitoring treatment progress, they rely almost solely on clinical observations in the residential milieu. Although the Counselors stated that they find it helpful to compare the baseline administration of the CCAT with the midpoint CCAT to obtain information about the effectiveness of their treatment interventions, they are not regularly administering the midpoint CCAT. Moreover, clinical decision making regarding client readiness for reintegration is currently based almost solely on clinical observations and client self-report. Although these are important forms of data to consider, using quantifiable data (e.g., CCAT) that can substantiate changes in clients during the course of treatment provides stronger evidence that clients are ready for reintegration as well as identifies remaining client risk factors for reintegration. The TCPS realizes this is a weakness of their current clinical decision making processes, and she plans to require the Counselors to discuss the findings from the midpoint CCAT in case management team meetings in the future. Even though the TIP-RC has been somewhat consistent in collecting data from the baseline CCAT and endpoint CCAT, they have not analyzed the results of this data in order to assess the stabilization and recovery outcomes for residential clients.

The clinical staff members also demonstrate a good ability to assess family and community needs based on systematically collected data, including individual interviews and direct observations that are part of the family and community assessments. They then develop reintegration plans based on the identified protective factors and risk factors from these client, family, and community assessments. The TIP-RC monitors the success of their reintegration plans during the community-based follow-up visits, using data from interviews with multiple stakeholders (e.g., reintegrated client, parents, teacher, and community chief), clinical observations, and the PRAT. Although the PRAT is supposed to be administered only at the 9-month follow-up visit, some of the clinical staff members stated that it would be helpful to administer it at every community-based follow-up visit because it provides comprehensive information about factors affecting the reintegration process. They reported that they immediately use this information to intervene in problem areas during follow-up visits, allowing them to modify reintegration plans based on this progress monitoring.

However, they do not address the PRAT findings in the case management team meetings, and discharge decisions for reintegrated clients (e.g., discontinuing monitoring activities) are based only on the interviews and clinical observations, not the PRAT. They have collected the PRAT data in order to assess reintegration outcomes of the TIP-RC Project, but they have not analyzed the results. Furthermore, they have not collected other forms of data to assess their reintegration outcomes, including the number of reintegrated clients that they have lost contact with before discharge from the program. Also, they assume reintegrated clients will lose weight after reintegration (due to food insecurity in normal community life) and they monitor this, via eye-balling their weight, to determine if clients' basic needs are being met by their post-reintegration

caregivers. However, if they weighed clients before reintegration and at every community-based follow-up visit, this could be another quantifiable data source used for progress monitoring and assessing program effectiveness. Thus, these findings indicate that even though the TIP-RC uses various forms of data to identify problems and develop interventions, they are missing opportunities to monitor intervention effectiveness at both an individual and a programmatic level.

3.4.4 Staff Self-Care Practices

Several authors have noted that working with VoT in victim assistance programs is stressful work, which can negatively affect staff members' physical and psychological well-being (IOM, 2007; Surtees, 2013; Zimmerman et al., 2003; Zimmerman & Borland, 2009). Therefore, these authors recommend that staff members regularly engage in self-care practices and receive support from management, which includes providing emotional support and clinical supervision, encouraging peer support, providing training on self-care and vicarious traumatization, and encouraging a work-life balance.

> Managers must be mindful that the stress confronting those providing care and services to traumatized persons, such as trafficked victims, results in a variety of psychological reactions that can cause secondary stress disorders and lead to secondary trauma. If constant stress is allowed to build up over time 'burnout' can occur. (IOM, 2007, p. 141)

TIP-RC staff members stated that the most stressful parts of their job include: (a) dealing with the judicial system; (b) interacting with implementing partners in the GOSL; (c) managing externalizing problems (e.g., verbal and physical aggression) in residential clients; (d) coping with high caseloads; (e) meeting documentation requirements; and (f) having long commutes to work. All interviewed staff members indicated that they engage in self-care practices, such as praying, singing, listening to music, and taking time off from work. However, few engage in these practices on a regular basis, which is mostly due to having limited free time available, being overly committed to work, and not seeing the importance of engaging in self-care practices.

Yet, generally staff members stated that their passion to help VoT as well as the support provided by WHI and their colleagues helped them cope with job-related stressors. Most felt adequately supported and trained by WHI to complete their job responsibilities, although many staff members indicated a strong desire to receive additional training "on any topic" to improve their caregiving skills. In particular, respondents found the clinical supervision and support provided at weekly staff meetings to be very beneficial, and they wanted this to be on-going. The TCPS has also organized approximately one self-care retreat per year for staff members, as well as offered shorter self-care opportunities in the regular schedule. She reported that the TIP-RC staff members need space and time to be away from the demands of both work and home. Additionally, the TCPS has found that having retreats that give space to staff members to openly talk about their emotions is very important to help them cope with the demands of their jobs, including their experiences with vicarious traumatization.

All interviewed staff members stated that they have experienced some elements of vicarious traumatization, including physical symptoms (e.g., headaches), insomnia, loss of appetite, emotional reactions (i.e., anger and sadness), and fear about loved ones being traumatized. This

is exacerbated by the fact that many respondents reported previous traumatic experiences in their own personal lives, such as war-related trauma, domestic violence, GBV, and human trafficking-related experiences. According to IOM (2007),

> A support person's personal history of abuse or discrimination can play a role in the way s/he is affected by a trafficked person's story, and may even impede their work. Where appropriate, it can be helpful to identify ways of broaching the subject of past abuse with support persons. For some individuals, discussing their personal experiences and gaining the understanding and support of management or colleagues can be a source of comfort and strength. (p. 247)

WHI has provided opportunities for employees to process their past traumatic experiences, via the caregiver training and the self-care retreats, which respondents stated were very healing and they helped them develop empathy for their clientele. One key informant stated, "Sometimes trauma hardens people and sometimes it softens people. For the shelter's staff, it has generally softened them." Moreover, there was general agreement among respondents that neither job-related stressors, nor vicarious traumatization have contributed to any staff retention issues. Thus, WHI seems to be adequately supporting the TIP-RC staff members, even though their individual use of self-care practices could be increased.

3.5 STABILIZATION AND RECOVERY OUTCOMES

A systematic review of peer-reviewed studies on the health risks of VoT – which primarily focused on adult female sex trafficking victims – indicated that they experience a high prevalence of physical, sexual, and mental health problems (Oram, Stockl, Busza, Howard, & Zimmerman, 2012). The most commonly reported physical health problems are back pain, stomach pain, headache, and memory problems. Moreover, these health problems are sufficiently problematic to generally impair the overall functioning of female sex trafficking victims (Zimmerman et al., 2006). VoT frequently experience a broad range of psychosocial difficulties (e.g., hostility, shame, diminished coping capacity, and interpersonal problems), whereas common psychiatric disorders include PTSD, anxiety disorders, mood disorders, dissociative disorders, and substance-related disorders (Alexander, Kellogg, & Thompson, 2005; IOM, 2006; Oram et al., 2012; Zimmerman et al., 2003, 2006). Studies (Abas et al., 2013; Ostrovschi et al., 2011) have found that the prevalence of psychiatric disorders in female sex trafficking victims range from 88% (immediately after emerging from their trafficking experiences) to 50% (6 months post-trafficking). These post-trafficking psychiatric disorders were independently predicted by a history of childhood sexual abuse, a longer duration of trafficking experiences, and post-trafficking stressors, including poor social support and greater unmet needs (Abas et al., 2013). One of the only studies looking at the health outcomes in labor trafficking victims concluded that both men and women trafficked for labor exploitation had high levels of physical and mental health problems post-trafficking, although their symptom levels were not as high as reported for female sex trafficking victims (Turner-Moss, Zimmerman, Howard, & Oram, 2013). Overall, these physical and mental health outcomes are most likely due to the high levels of physical violence, sexual violence, and other forms of abuse (e.g., abusive living and working conditions, social restrictions, economic exploitation) often experienced by both sex and labor trafficking victims (Oram et al., 2012; Turner-Moss et al., 2013; Zimmerman et al., 2003).

Little is known about the physical or mental health outcomes for child trafficking victims because of the paucity of systematic empirical research on this topic (Oram et al., 2012; Rafferty, 2013). Qualitative research in the Greater Mekong sub-region in Asia found that child trafficking victims often experienced: (a) exploitation from a young age that negatively impacted their physical and psychological development; (b) trauma due to experiencing or witnessing physical, sexual, and psychological violence while trafficked; (c) physical problems due to the harsh working and living conditions while trafficked; (d) long, and often multiple, periods of exploitation; and (e) serious problems in their family-of-origin (e.g., abuse) before being trafficked (Surtees, 2013).

As a result, child trafficking victims need specialized and developmentally appropriate aftercare services for successful recovery (Surtees, 2013). Based on a systematic review of the aftercare service delivery literature for child sex trafficking victims, Muraya and Fry (2016) state that the recovery phase,

> . . . is characterized by intense person-centered service provision aimed at restoring the physical and mental health of the child and building their resilience while his or her legal status is determined. Key services provided in this phase are legal aid, medical care, psychosocial care, and accommodation. (p. 212)

There is consensus in the aftercare literature that these services should be comprehensive in nature, including residential care, physical health care, mental health care, chemical dependency treatment, education, vocational training, life skills education, and legal support (IOM, 2006; Macy & Johns, 2011; Muraya & Fry, 2016; Surtees, 2013; Zimmerman et al., 2006). Although there is agreement on the recommended aftercare services for the recovery of VoT, there is currently no research that assesses the impact of these services on outcomes related to the stabilization and recovery of either adult or child trafficking victims (Muraya & Fry, 2016).

Also, there have been almost no published programs evaluations of trafficking victim assistance programs that provide information about outcomes, especially in regards to quantitative data on the impact of these programs on clients (Potocky, 2010). In one of the few program evaluations of a comprehensive case management program for VoT in Florida, Potocky found 42% of client goals were obtained, but there was documented improvement in only 36% of client outcomes (i.e., shelter & food, medical, psychosocial needs, employment/education, literacy, legal & immigration issues, and life skills) during the course of services. In addition, several of the outcomes were correlated with each other (e.g., improvements in mental health were correlated with improvements in employment/education and immigration status), which supports the need to provide comprehensive care to VoT.

According to the TIP-RC's logic model (see Annex 12), stabilization and recovery of VoT is the intended outcome of the comprehensive aftercare services provided during residential care at the shelter. All TIP-RC respondents stated that stabilizing clients before reintegration was very important for reintegration to be successful. Otherwise, VoT are at a greater risk to be stigmatized for their mental health symptoms, less able to form healthy social supports, and less able to maintain adequate educational and vocational functioning once they are reintegrated. Moreover, all of these possible negative outcomes increase their risk for future exploitation. WHI believes that shelter-based care provides more intensive treatment than community-based care, allowing trafficking victims to more quickly stabilize and recover.

Therefore, the following indicators were used to determine how effective the TIP-RC Project has been in stabilizing and recovering VoT during the course of residential care: (a) reduced physical health symptoms; (b) reduced mental health symptoms, including trauma-related symptoms, internalizing problems, and externalizing problems; (c) improved coping skills; (d) improved prosocial behaviors; (e) improved self-confidence; (e) improved self-protection skills; (f) improved academic and/or vocational functioning; and (g) improved spiritual resources. These variables were chosen based on the factors associated with positive reintegration outcomes (see Section 3.6 for a review of this research) because successful reintegration is the intended outcome of client stabilization and recovery during residential care. Moreover, these indicators were assessed by using the CCAT to measure the relevant stabilization and recovery outcomes at baseline (i.e., within 2 weeks of admission), midpoint (i.e., about 3-4 months after admission), and endpoint (i.e., about 1 week before leaving residential care).

Although the TIP-RC began utilizing the CCAT in August 2014 during the Ebola lockdown of the shelter, data from the Ebola period was not utilized in the stabilization and recovery outcome analyses because WHI was unable to obtain baseline CCAT data on clients in the shelter. During the Ebola period, the mean length time between admission to the shelter and the first administration of the CCAT was 6.2 months. Moreover, a review of the CCAT data from this time period suggests several errors in administration, which reflects a possible learning curve in regards to using the instrument.

Therefore, only CCAT data collected after the TIP-RC reopened in October 2015 was used. A total of 30 residential clients were administered the baseline CCAT, although 2 clients were only administered the client version and 2 other clients were only administered the clinician version. The mean length time between residential admission and the administration of the baseline CCAT was 6.1 days (*SD* = 8.7 days). The sample consisted of all female clients with a mean age of 13.1 years (*SD* = 4.3 years), ranging from ages 6 to 25. Twenty-four clients were labor trafficking victims (80%), 4 were sex trafficking victims (13%), and 2 were other victims vulnerable to human trafficking (7%). For the trafficking victims in the sample, the mean length of time spent in trafficking was 13.9 months (*SD* = 1 month), ranging from 2 days to 9 years.

Table 10 reports the descriptive statistics for the baseline administration of the CCAT. Due to the reverse scoring procedures discussed in Section 1.3, higher scores on all the scales indicate a higher frequency of symptoms or more serious problems. Although there was quite a bit of variability between clients in regards to their reported rates of mental health symptoms and psychosocial functioning when they entered residential care, the clients, on average, tended to have more problems with trauma-related symptoms and poorer self-protection skills. Few TIP-RC clients reported problems with utilizing spiritual resources to help them cope with stressors, indicating that spiritual coping is commonly an area of strength for the clientele. Also, age at admission was correlated significantly with the following baseline CCAT scales: Trauma (r = .47, p = .01), Anxiety & Depression scale (r = .54, p = .003) and Confidence (r = -.41, p = .03). Thus, older clients tended to report more trauma-related symptoms, more internalizing problems, yet more self-confidence when admitted to the shelter. The total time spent in trafficking was significantly and positively correlated with the following baseline CCAT scales: Hostility (r = .73, p < .001), Prosocial Behavior (r = .46, p = .02), Confidence (r = .49, p = .01), and Coping

Skills (r = .46, p = .02). This indicates that longer periods of trafficking-related exploitation was associated with clients at admission having more externalizing problems, less prosocial behaviors, less self-confidence, and less coping skills to manage on-going psychosocial problems.

To explore comorbidities between outcomes at baseline, correlation coefficients were computed for baseline CCAT scales, which are presented in Table 11. First, clients who reported more trauma-related symptoms tended have more internalizing problems. Second, clients who reported more hostility or externalizing problems at admission tended to have more internalizing problems, less prosocial behaviors, less self-confidence, fewer coping skills, yet greater self-protection skills. Lastly, clients who reported less self-confidence when they were admitted to the shelter tended to demonstrate poorer educational and vocational functioning when they first began attending the educational and vocational classes in the shelter.

Of the initial sample of 30 clients, only 24 were administered the midpoint CCAT, at a mean length of 3.4 months (SD = 0.88 months) after being admitted to the TIP-RC. However, 4 of these clients were only administered the client version and 2 clients were only administered the clinician version. Of the 6 clients who were not administered the midpoint CCAT, 3 of them had not been in residential care long enough to reach the midpoint administration timeframe, whereas the remaining 3 clients were reintegrated without collecting midpoint CCAT data on them. Of the initial sample of 30 clients, 13 clients have been reintegrated (43%), whereas 17 are currently in residential care (57%). For the 13 reintegrated clients, the mean length of time in residential care before reintegration was 3.4 months (SD = 1.72 months), ranging from 52 days to 6.4 months. However, only 8 of the 13 reintegrated clients were administered the endpoint CCAT, including 1 client who was only administered the clinician version, at a mean length of 3.5 months (SD = 1.93 months) after being admitted to the shelter. It is important to note that the means mentioned in this paragraph vary due to the inconsistent administration of the CCAT (e.g., some of the clients administered the endpoint CCAT were different than the clients administered the midpoint; and not all the reintegrated clients were administered the endpoint CCAT).

Still, the mean length of time in residential care was significantly and positively correlated with age at admission (r = .65, p = .02) and the total time spent in trafficking (r = .61, p = .04), indicating that older clients and clients who experienced longer periods of trafficking-related exploitation tended to spend more time in residential care before reintegration. The mean length of time in residential care was also significantly and positively correlated with the following baseline CCAT scales: Trauma (r = .62, p = .04), Anxiety & Depression (r = .87, p = .001), and Coping Skills (r = .72, p = .01). This means that clients that were admitted to the TIP-RC with more trauma-related symptoms, more internalizing problems, and poorer coping skills tended to spend more time in residential care before being reintegrated.

Although it was initially planned to conduct a one-way repeated measures ANOVA to determine changes in the CCAT scores over the 3 administration periods, this statistical analysis could not be conducted because (a) a high percentage of the sample had not been in residential care long enough to reach the endpoint administration timeframe; and (b) there were many missing data points due to inconsistent administration of the CCAT. Instead, paired-samples t-tests were

conducted between baseline CCAT scales and midpoint CCAT scales to determine if there were any statistical changes between reported levels of symptoms during the course of residential care. Paired-samples t-tests were also conducted between baseline CCAT scales and endpoint CCAT scales to determine possible statistical changes from the beginning until the end of residential care, although these analyses should be considered exploratory due to the small sample size. In addition, Cohen's *d* statistics were calculated to determine the effect size for each of these analyses. Traditionally, *d* values of .2, .5, and .8 represent small, medium, and large effect sizes, respectively.

Table 12 presents the results from the analyses comparing baseline to midpoint scores on the CCAT. Overall, clients showed significant improvements, with mostly large effect sizes, on 7 of the 10 CCAT scales, after a mean length of 3.4 months in residential care at the TIP-RC. In particular, clients showed significant reductions in physical health problems, trauma-related symptoms, and internalizing problems, as well as significant improvements in self-confidence, educational and vocational functioning, coping skills, and self-protection skills. It is important to note that these improvements occurred before the end of residential care; therefore, additional gains could possibly occur over the remaining course of shelter-based care.

Table 13 presents the results from the exploratory analyses comparing baseline to endpoint scores on the CCAT. Given the small sample size and the resulting low statistical power, it is noteworthy that clients showed significant improvements, with large effect sizes, on 4 of the 10 CCAT scales between admission and discharge from residential care at the TIP-RC. In particular, clients showed significant reductions in trauma-related symptoms and internalizing problems, as well as significant improvements in coping skills and self-protection skills. Although not statistically significant, clients also showed improvements, with large effect sizes, in physical health and self-confidence.

Table 14 presents perception data from the TIP-RC clinical staff members about how beneficial they view the various TIP-RC services in contributing to the stabilization and recovery of clients while in residential care. As indicated in Table 14, clinical staff members believe that the majority of the shelter services, and some of the reintegration services, are either extremely beneficial or very beneficial in helping their clientele to stabilize and recovery. Moreover, several TIP-RC key informants stated that an additional important factor in the stabilization and recovery of clients is the facilitative conditions (e.g., empathy and unconditional positive regard) of the therapeutic relationships established in the residential milieu. According to one staff member, "The love and care provided by the staff are very important. Some clients have never experienced this before. Even though they act out, everyone still loves them and accepts them. This is key to the services being helpful." Still, it is important to note that the clinical staff members generally felt that legal support was extremely beneficial in helping trafficking victims heal from their exploitation, especially when perpetrators are punished. Yet, they provided lower ratings for the legal support services offered by the TIP-RC Project because they are currently insufficient in obtaining justice for the majority of their clientele.

Table 10

Descriptive Statistics for the Baseline CCAT Scales

Scale	*n*	*M*	*SD*	Minimum	Maximum	Range
Trauma	28	2.10	.66	1.00	3.63	2.63
Anxiety & Depression	28	1.83	.51	1.13	2.88	1.75
Hostility	28	1.59	.65	1.00	3.50	2.50
Prosocial Behavior	28	1.62	.26	1.20	2.29	1.09
Confidence	28	1.71	.38	1.00	2.60	1.60
Spirituality	25	1.32	.37	1.00	2.00	1.00
Physical Health (Item 1)	28	1.64	.83	1.00	4.00	3.00
Educational/Vocational	28	1.56	.71	1.00	3.88	2.88
Coping Skills	28	1.54	.41	1.00	2.86	1.86
Self-Protection Skills	28	2.04	.50	1.17	3.33	2.17

Note. CCAT scores are based on a Likert scale from 1 to 4, with 1 indicating “not at all” or “not at all a problem” and 4 indicating “always” or “serious problem.”

Table 11

Zero-Order Correlations Between Baseline CCAT Scales

Scale	1	2	3	4	5	6	7	8	9	10
1. Trauma	1.00									
2. Anxiety/Depression	.65***	1.00								
3. Hostility	.32	.59**	1.00							
4. Prosocial Behavior	-.12	.18	.42*	1.00						
5. Confidence	-.23	.02	.49**	.47*	1.00					
6. Spirituality	-.29	.09	.20	-.20	.11	1.00				
7. Physical Health	.24	-.17	-.08	-.01	-.08	-.25	1.00			
8. Education/Vocation	-.03	-.06	.27	.14	.48*	.20	.12	1.00		
9. Coping Skills	.36	.21	.45*	-.10	.17	.22	.36	.32	1.00	
10. Self-Protection Skills	-.02	.10	-.42*	.03	-.17	-.01	-.15	.00	-.17	1.00

* $p < .05$ ** $p < .01$ *** $p < .001$

Table 12

Paired-Samples T-Tests and Effect Sizes Between Baseline and Midpoint CCAT Scales

	Baseline		Midpoint				
Scale	*M*	*SD*	*M*	*SD*	*df*	*t*	Cohen's *d*
Trauma	1.96	.55	1.45	.36	21	5.83***	1.24
Anxiety & Depression	1.77	.45	1.41	.40	21	5.20***	1.11
Hostility	1.49	.63	1.40	.57	21	1.77	0.38
Prosocial Behavior	1.61	.24	1.51	.15	21	1.85	0.40
Confidence	1.70	.40	1.38	.40	21	4.11**	0.88
Spirituality	1.37	.35	1.32	.70	18	0.29	0.06
Physical Health	1.47	.61	1.00	.00	18	3.38**	0.77
Educational/Vocational	1.57	.80	1.26	.50	17	2.34*	0.55
Coping Skills	1.55	.42	1.25	.25	18	4.44***	1.02
Self-Protection Skills	2.15	.48	1.34	.37	198	7.00**	1.61

* $p < .05$ ** $p < .01$ *** $p < .001$

Table 13

Paired-Samples T-Tests and Effect Sizes Between Baseline and Endpoint CCAT Scales

	Baseline		Endpoint				
Scale	*M*	*SD*	*M*	*SD*	*df*	*t*	Cohen's *d*
Trauma	2.45	.81	1.52	.39	6	4.67**	1.76
Anxiety & Depression	1.77	.50	1.34	.26	6	3.98**	1.50
Hostility	1.28	.33	1.23	.39	6	0.57	0.22
Prosocial Behavior	1.53	.29	1.49	.19	6	0.28	0.10
Confidence	1.34	.25	1.17	.18	6	2.12	0.80
Spirituality	1.19	.26	1.14	.18	6	0.42	0.16
Physical Health	1.88	1.13	1.00	.00	7	2.20	0.78
Educational/Vocational	1.23	.31	1.04	.08	7	1.67	0.59
Coping Skills	1.58	.27	1.30	.25	7	3.51*	1.24
Self-Protection Skills	2.00	.71	1.23	.21	7	3.57**	1.26

* $p < .05$ ** $p < .01$ *** $p < .001$

Table 14

Perception Data from Clinical Staff Members about the Contribution of TIP-RC Services Towards the Stabilization and Recovery of Residential Clients (n=5)

TIP-RC Services	*M*	*SD*
Residential care	3.6	0.5
Medical care	4.0	0.0
Health education	3.2	0.8
Individual counseling	3.8	0.4
Group counseling	3.3	0.6
Psychoeducation & life skills training	3.8	0.5
Educational services	2.6	0.5
Vocational training	2.6	0.5
Social and recreational activities	3.4	0.5
Family tracing	4.0	0.0
Family bonding visits	3.8	0.4
Client assessments	3.7	0.6
Family assessments	2.6	0.5
Community assessments	2.8	0.8
Family mediation	3.8	0.4
Family education on TIP & child protection issues	3.4	0.9
Community education on TIP & child protection issues	3.4	0.5
Legal support	3.2	1.1

Note. Ratings are based on a Likert scale from 1 to 4, with 1 indicating “not beneficial” and 4 indicating “extremely beneficial.”

3.6 REINTEGRATION OUTCOMES

Successfully reintegrating VoT back into normal community life is the goal of most trafficking victim assistance programs. However, the human trafficking aftercare literature lacks an operational definition of successful reintegrations, which hinders the ability of organizations to measure reintegration outcomes (Muraya & Fry, 2016). Currently, there is no empirical research that measures rates of reintegration outcomes after the provision of victim assistance (Potocky, 2010). Essentially, there are no established norms regarding reintegration outcomes for aftercare programs.

Crawford and Kaufman (2008) attempted to assess reintegration outcomes through a systematic analysis of case files at a NGO in Nepal, which provides aftercare services to female survivors of trafficking or GBV based on current best practices. Their findings were limited because reintegration outcomes were not scaled. Yet, Crawford and Kaufman concluded that three-quarters of the sample were reintegrated in their home villages and were accepted by their family members. In a program evaluation of the Cambodian government's victim assistance program for VoT, both NGO personnel and government social workers estimated that only 50% of cases had positive reintegration outcomes due to high rates of poverty and psychosocial problems for reintegrated clients (Sammon, 2009). However, these are just estimates and they are not based on measured outcomes. Another program evaluation of three victim assistance programs providing comprehensive case management services for child trafficking victims in the United States reported that the programs lost contact with a significant portion of their clientele during the course of service provision, ranging from 15%-51% of the cases closed by the programs (Gibbs, Hardison Walters, Lutnick, Miller, & Kluckman, 2015). As a result, Gibbs et al. stated that losing contact with clients should be considered a primary outcome of program evaluations for child trafficking assistance programs. They also suggested that other outcome areas that should be assessed include indicators of safety, well-being, permanent connections, and self-sufficiency.

Furthermore, there has been limited empirical research looking at the factors associated with positive or negative reintegration outcomes, with the majority of the studies being qualitative in nature and only two being peer-reviewed (Arensen et al., 2004; Brunovski & Surtees, 2012; Chenda, 2008; Crawford & Kaufman, 2008; Jobe, 2010; Reimer et al., 2007; Surtees, 2013). A review of this literature found preliminary evidence that the following community or family factors are associated with negative reintegration outcomes: (a) poor environmental conditions in the reintegration community (e.g., economic and social difficulties, limited employment and educational opportunities, gender inequality, and civil conflict); (b) community or family stigma; (c) limited family support or unresolved problems in the family-of-origin; and (d) the lack of sustainable income in the reintegration family. The following client factors seem to be associated with negative outcomes post-reintegration: (a) chronic physical health problems; (b) on-going mental health problems or psychosocial difficulties; (c) limited prosocial behaviors (e.g., social withdrawal, aggression, and overtly sexualized behaviors); and (d) limited educational or vocational skills. There is some preliminary evidence that unassisted VoT (i.e., not receiving any formal victim assistance support following trafficking experiences) often had worse reintegration outcomes, even though healthy family dynamics, social support, and positive social context helped some unassisted VoT overcome their trafficking experiences (Surtees, 2013).

To supplement the limited research available on factors associated with reintegration outcomes, the literature on reintegrated former child soldiers in Sierra Leone was reviewed (Betancourt, Agnew-Blais, Gilman, Williams, & Ellis, 2010; Betancourt, Borisova, et al., 2010; Betancourt, Brennan, et al., 2010; Betancourt, McBain, & Brennan, 2014; Betancourt, McBain, Newnham, & Brennan, 2013; Betancourt, Newnham, McBain, & Brennan, 2013; Betancourt et al., 2008; Borisova et al., 2013).

> Although there are some distinct differences between VoT and former child soldiers, there are several characteristics of this population that make them similar to the TIP-RC clientele including: (a) they are Sierra Leonean children who generally experienced involuntary separation from their families; (b) they were primarily used as domestic slaves (e.g., cooking, laundering, and carrying heavily loads); and (c) a high frequency of the females were raped or sexually abused during their war-time experiences. (Betancourt et al., 2008 as cited in Barnett, 2013, p. 30)

Longitudinal research on the reintegration of former child soldiers in Sierra Leone found that their long-term mental health after reintegration was affected by both war-related trauma exposure and post-conflict contextual factors. High trauma exposure during the war, especially surviving rape or perpetrating violence against others, was a risk factor for poor psychosocial adjustment after reintegration. In addition, the following post-conflict risk factors were associated with poor psychosocial adjustment after reintegration: community stigma, economic hardships, and family abuse or neglect after reintegration. Former child soldiers who lacked support after reintegration, due to community stigma or family maltreatment, generally had worsening mental health symptoms, including internalizing problems (i.e., depression and anxiety), externalizing problems (i.e., aggression and hostility), and posttraumatic stress symptoms. However, several post-conflict protective factors fully or partly mitigated the negative effects of war experiences and post-conflict risk factors on the long-term mental health of reintegrated former child soldiers. These protective factors include community acceptance, family acceptance, social support, caregiver-child communication about war-related experiences, and access to education.

Based on the above research findings and qualitative data from the 2013 TIP-RC Evaluation (Barnett, 2013), the following indicators were used to determine how effective the TIP-RC Project has been in successfully reintegrating VoT in the Sierra Leonean community: (a) the percentage of reintegrated clients the TIP-RC maintained contact with until discharge from program; (b) low levels of exploitation risk factors in reintegrated clients; (c) high levels of psychosocial adjustment in reintegrated clients; (d) high levels of family acceptance and support experienced by reintegrated clients; (e) high levels of community acceptance experienced by reintegrated clients; and (f) high levels of academic or vocational functioning in reintegrated clients. This was assessed using data collected from the PRAT, which is supposed to be administered to reintegrated clients about 9 months post-reintegration.

At the time of the 2013 TIP-RC Evaluation (Barnett, 2013), the TIP-RC recorded the date of last known contact with reintegrated clients, if they lost contact with them before they were fully discharged from the program (i.e., before reintegration support services were discontinued). However, the TIP-RC no longer tracks this information partially because they have lost contact with very few reintegrated clients during the course of the project. Key informants at the TIP-RC stated that out of the 89 reintegrated clients, they have lost contact with approximately 3 of them

before fully discharging them from the program (3% of all reintegrated clients). This reported frequency and percentage should be used cautiously because its accuracy could not be verified by any TIP-RC documentation.

At the time of the field research, the TIP-RC had only been reopened for 8 months; therefore, there was not enough PRAT data collected on TIP-RC clients from this time period to complete the desired data analyses. Thus, the PRAT data from the post-Ebola period was combined with the PRAT data collected from the Ebola period to increase the sample size. This sample included a total of 18 reintegrated clients who were administered the PRAT, including 11 clients from the Ebola period (61%) and 7 clients since the shelter reopened in October 2015 (39%). The mean length of time in residential care before reintegration was 10.7 months (*SD* = 7.6 months), ranging from 52 days to 2.03 years. It is important to note that the length of residential care is impacted by the sample consisting of a high percentage of clients from the Ebola period, when the TIP-RC could not reintegrate clients for at least for 6 months or more due to the National State of Emergency and the resulting travel restrictions around the country. Correlation coefficients were computed between the mean length of time in residential care and the PRAT scales: Trauma (r = -.35, p = .17), Anxiety & Depression (r = -.08, p = .76), Hostility (r = -.09, p = .74), Prosocial Behavior (r = .02, p = .95), Confidence (r = -.29, p = .26), Spirituality (r = -.42, p = .10), Educational/Vocational Functioning (r = -.10, p = .68), Coping Skills (r = .13, p = .60), Self-Protection Skills (r = -.19, p = .45), Family Acceptance & Support (r = .25, p = .34), Community Acceptance (r = -.21, p = .42), Family Risk Factors (r = .15, p = .59), and Community Risk Factors (r = .00, p = .99). Because no significant correlations were found from these analyses, it was determined that the mean length of time in residential care was not significantly related to any of the reintegration outcomes and it should not be problematic to include the PRAT data from the Ebola period in the rest of the data analyses.

The total sample consisted of all female clients with a mean age of 10.8 years (*SD* = 3.4 years), ranging from ages 6 to 17. Eight clients were labor trafficking victims (45%), 4 were sex trafficking victims (22%), and 6 were other victims (i.e., primarily rape victims) vulnerable to human trafficking (33%). There was incomplete data to calculate the mean time spent in trafficking for the trafficking victims in the sample. Of the total sample of 18 reintegrated clients, 5 of these clients were reintegrated into communities with an active VPG or WMF (28%). Due to the small sample size as well as the fact that four of these clients were reintegrated into the same community, this data was not utilized for additional analyses. The mean length time between reintegration and the administration of the PRAT was 7.8 months (*SD* = 3.7 months), ranging from 2 months to 15.1 months. This variability is due to WHI temporarily moving up the timeframe of the PRAT administration for several post-Ebola clients in order to provide more data for this evaluation. It is important to note that several of the demographic variables for this sample vary significantly in comparison to the sample used in the data analyses for the stabilization and recovery outcomes, as well as the descriptive statistics for the overall TIP-RC clientele (see Section 2.2.5). Therefore, this sample is not completely representative of the TIP-RC clientele, and any findings from these analyses should be considered as exploratory and not authoritative.

Table 15 reports the descriptive statistics for the baseline administration of the PRAT. Due to the reverse scoring procedures discussed in Section 1.3, higher scores on all the scales indicate a

higher frequency of symptoms or more serious problems. On average, the reintegrated clients tended to report more trauma-related symptoms and internalizing problems, whereas few problems were identified for physical health symptoms, coping skills, and community risk factors after a mean length of 8 months post-reintegration. Due to the sample not being fully representative of the TIP-RC clientele, correlation coefficients were not conducted between demographic variables and the PRAT scales. In order to determine the percentage of the sample that had good reintegration outcomes and poor reintegration outcomes for each variable measured, the reintegrated clients (n = 18) were categorized based on their mean scores for each PRAT scale using the following criteria: Good Outcomes (M = 1.00-2.49) and Poor Outcomes (M = 2.5-4.0). The criteria used to indicate Poor Outcomes mean that clients reported on average at least a moderate frequency of symptoms or the TIP-RC clinicians identified on average at least a moderate problem-level for the reintegrated clients. Table 16 presents an overview of the frequencies and percentages of reintegrated clients categorized with Good Outcomes and Poor Outcomes for each of the PRAT scales.

Of the 18 reintegrated clients, only 9 of these clients were administered the endpoint CCAT before they were reintegrated. Although these analyses should be considered exploratory due to low statistical power related to the small sample size, paired-samples t-tests were conducted between these endpoint CCAT scales and the PRAT scales to determine possible statistical changes from the end of residential care until, on average, 8 months after reintegration. In addition, Cohen's d statistics were calculated to determine the effect size for each of these analyses. Table 17 presents the results from the exploratory analyses comparing the endpoint CCAT scales to the PRAT scales. Even with the small sample size, clients showed significant increases in self-reported symptoms and identified problems, with large effect sizes, on 5 of the 10 CCAT/PRAT scales between discharge from residential care and, on average, 8 months after reintegration. In particular, clients showed significant increases in trauma-related symptoms and internalizing problems, as well as significant declines in self-confidence, spiritual resources, and self-protection skills. This means that gains were not maintained in these areas once clients were reintegrated into normal Sierra Leone community life. Because most of this sample was not administered the baseline CCAT, it is unknown whether these reintegrated clients returned to a level functioning similar to when they entered the TIP-RC.

Table 18 presents perception data from the TIP-RC clinical staff members about how beneficial they view the various TIP-RC services in contributing to positive reintegration outcomes in clients 12 months after reintegration. As indicated in Table 18, clinical staff members believe that the majority of the shelter services and the reintegration support services are either extremely beneficial or very beneficial in helping clients experience successful reintegration into Sierra Leone society. This indicates that the clinical staff members believe that VoT benefit from the provision of comprehensive services, which corresponds with international best practices and the recommendations in the aftercare service delivery literature (IOM, 2006; Macy & Johns, 2011; Muraya & Fry, 2016; Potocky, 2010; Surtees, 2013; Zimmerman et al., 2006). However, the clinical staff members, on average, thought that the following TIP-RC services were only somewhat beneficial in contributing to positive reintegration outcomes: shelter-based educational services, shelter-based vocational services, shelter-based social and recreational activities, and the reintegration support packages. Overall, they believe that the social and recreational activities in the shelter are beneficial for stabilizing clients, but they have a less significant impact on

reintegration outcomes. Conversely, clinical staff members generally thought that the other identified service areas need to be improved in order to facilitate better reintegration outcomes.

Table 15

Descriptive Statistics for the PRAT Scales

Scale	*n*	*M*	*SD*	Minimum	Maximum	Range
Trauma	17	2.08	.57	1.00	3.25	2.25
Anxiety & Depression	17	2.18	.49	1.13	2.94	1.81
Hostility	17	1.61	.56	1.00	2.67	1.67
Prosocial Behavior	17	1.66	.45	1.00	2.71	1.71
Confidence	17	1.81	.42	1.20	3.00	1.80
Spirituality	17	1.61	.47	1.00	2.33	1.33
Physical Health (Item 1)	18	1.00	.00	1.00	1.00	0.00
Educational/Vocational	18	1.93	1.18	1.00	4.00	3.00
Coping Skills	18	1.19	.28	1.00	2.00	1.00
Self-Protection Skills	18	1.77	.83	1.00	3.50	2.50
Family Acceptance	17	1.87	.59	1.00	3.20	2.20
Community Acceptance	17	1.73	.50	1.00	2.60	1.60
Family Risk Factors	16	1.89	.67	1.00	2.86	1.86
Community Risk Factors	16	1.03	.10	1.00	1.40	0.40

Note. PRAT scores are based on a Likert scale from 1 to 4, with 1 indicating “not at all” or “not at all a problem” and 4 indicating “always” or “serious problem.”

Table 16

Categorization of Reintegration Outcomes Based on PRAT Scale Scores

	Good Outcomes		Poor Outcomes	
Scale	*n*	*%*	*n*	*%*
Exploitation Risk Factors				
Physical Health	18	100	0	0
Family Risk Factors	12	75.0	4	25.0
Community Risk Factors	16	100	0	0
Psychosocial Adjustment				
Trauma	13	76.5	4	23.5
Anxiety & Depression	11	64.7	6	35.3
Hostility	15	88.2	2	11.8
Prosocial Behavior	16	94.1	1	5.9
Confidence	16	94.1	1	5.9
Spirituality	17	100	0	0
Coping Skills	18	100	0	0
Self-Protection Skills	13	72.2	5	27.8
Family Acceptance & Support	15	88.2	2	11.8
Community Acceptance	16	94.1	1	5.9
Educational/Vocational Functioning	11	61.1	7	38.9

Note. The table indicates the frequency and percentage of cases who obtained mean scores for each PRAT scale based on the following criteria: Good Outcomes (M = 1.00-2.49) and Poor Outcomes (M = 2.5-4.0)

Table 17

Paired-Samples T-Tests and Effect Sizes Between Endpoint CCAT Scales and PRAT Scales

	Endpoint CCAT		PRAT				
Scale	*M*	*SD*	*M*	*SD*	*df*	*t*	Cohen's *d*
Trauma	1.31	.21	2.00	.58	8	-2.92*	-0.97
Anxiety & Depression	1.49	.26	2.22	.44	8	-4.25**	-1.42
Hostility	1.23	.17	1.63	.59	8	-2.17	-0.72
Prosocial Behavior	1.51	.13	1.58	.30	8	-0.65	-0.22
Confidence	1.37	.31	1.80	.26	8	-2.62*	-0.87
Spirituality	1.04	.11	1.63	.48	8	-3.83**	-1.27
Physical Health	1.11	.33	1.00	.00	8	1.00	0.33
Educational/Vocational	1.04	.06	1.81	1.12	8	-2.10	-0.70
Coping Skills	1.21	.20	1.25	.33	8	-0.29	-0.10
Self-Protection Skills	1.15	.15	2.01	.73	8	-3.68**	-1.23

* $p < .05$ ** $p < .01$ *** $p < .001$

Table 18

Perception Data from Clinical Staff Members about the Contribution of TIP-RC Services Towards Positive Reintegration Outcomes (n=5)

TIP-RC Services	*M*	*SD*
Residential care	3.0	0.7
Medical care	3.8	0.4
Health education	3.4	0.5
Individual counseling	3.4	0.9
Group counseling	3.0	0.0
Psychoeducation & life skills training	3.3	0.5
Educational services	2.6	0.9
Vocational training	2.4	1.1
Social and recreational activities	2.8	0.8
Family tracing	4.0	0.0
Family bonding visits	4.0	0.0
Client assessments	3.7	0.6
Family assessments	3.4	0.9
Community assessments	3.4	0.5
Family mediation	3.8	0.4
Family education on TIP & child protection issues	3.8	0.4
Community education on TIP & child protection issues	3.0	0.7
Reintegration support packages	2.4	0.5
Monitoring phone calls	3.2	0.8
Community-based monitoring visits	3.6	0.5
Legal support	3.0	1.0

Note. Ratings are based on a Likert scale from 1 to 4, with 1 indicating “not beneficial” and 4 indicating “extremely beneficial.”

4.0 CONCLUSIONS

Based on the reviewed findings, it can be concluded that the TIP-RC Project has obtained successful results in a challenging environment. There is substantial evidence that the TIP-RC provides high quality, comprehensive aftercare services for primarily young female VoT in Sierra Leone. WHI has successfully adapted recommendations from the aftercare service delivery literature (see Grant & Hudlin, 2007; Macy & Johns, 2011; Muraya & Fry, 2016) to offer an effective program model that meets the holistic needs of trafficking victims in a low resourced environment, characterized by the lack of adequate social services and limited qualified service providers. The conclusions for each evaluation question will be reviewed in more detail below, but as a whole, they provide considerable support for the TIP-RC Project to be considered a best practice model for child trafficking victim assistance programs in West Africa.

However, one of the major weaknesses of the TIP-RC Project is that it lacks a sustainability plan in regards to funding. This is partly due to the lack of funding from the GOSL. Yet, another reason involves the inherent problems of providing high quality comprehensive care; it is more expensive to provide these services than to offer either limited community-based services or a lower standard of care. Currently, offering comprehensive aftercare services is the gold standard for trafficking victim assistance programs (Macy & Johns, 2011; Muraya & Fry, 2016), but it is very expensive to implement all the recommended practices from the aftercare service delivery literature. In fact, many of the areas in the TIP-RC service delivery model that have been identified as needing improvement (e.g., legal support, reintegration monitoring practices, and reintegration support packages) are due to either staffing or resource limitations based on their current funding levels. It is currently unknown what level of aftercare services are needed to obtain successful reintegration outcomes for VoT, yet there is some preliminary evidence that trafficking victims do better post-reintegration when they have been provided comprehensive victim assistance (Surtees, 2013). Even though high quality comprehensive aftercare services are initially more expensive to provide, it is possible that they offer a better long-term investment in protecting trafficking victims, if less expensive victim assistance models result in poorer reintegration outcomes. Future research studies and program evaluations of victim assistance programs are needed to answer these questions. In the meantime, there is ample evidence from this evaluation that the TIP-RC program model is generally effective in supporting the recovery of primarily child trafficking victims and then successfully reintegrating them into normal community life in a low resourced country.

4.1 COOPERATION WITH PARTNER ORGANIZATIONS

Adequate victim protection and assistance require the development of interdisciplinary and collaborative partnerships between government agencies, law enforcement, human service providers, and NGOs (Gjermeni & Van Hook, 2012; Macy & Johns, 2011; Okech, Morreau, & Benson, 2011; Reimer, Langeler, Sophea, & Montha, 2007; Surtees, 2013). Even in well-resourced countries, inter-agency collaboration between service providers is necessary to provide comprehensive aftercare services (Macy & Johns, 2011). In low resourced countries with limited service providers, these collaborative partnerships are even more important. The TIP-RC service delivery model is based on building and maintaining these interdisciplinary and collaborative

partnerships in order to provide a high quality of care while controlling, or even decreasing, program costs. Because WHI had a long track-record of engaging in reputable anti-trafficking work in Sierra Leone before establishing the TIP-RC Project, WHI had an easier time forming the partnerships needed to support and enhance this project. Overall, cooperation with partner organizations contributes to the TIP-RC program model in several ways, including: (a) receiving official recognition from the GOSL; (b) improving victim identification and the use of referrals mechanisms to obtain psychosocial care for identified victims; (c) providing free or discounted medical care to adequately address clients' physical health problems; (d) offering residential care through alternative care providers for referred cases that do not meet the TIP-RC's residential admission criteria and for clients who cannot be reintegrated with family members; (e) supplementing the TIP-RC's reintegration support services with assistance from implementing partners (e.g., helping with family tracing and monitoring reintegrated cases); and (f) offering some assistance with their clients' immigration and legal issues. Developing collaborative partnerships with a wide range of organizations is one of the key factors in the TIP-RC's ability to provide high quality comprehensive aftercare services in Sierra Leone.

However, the TIP-RC Project has faced significant problems in providing effective legal support to VoT in Sierra Leone. There are substantial systemic problems in both the SLP and the judiciary, which negatively impact human trafficking related prosecutions and convictions in Sierra Leone. Addressing the majority of these issues is beyond the scope of the TIP-RC Project. Yet, the TIP-RC program model has been effective in increasing trafficking victims' access to the justice system, but this has not translated into increased convictions of TIP perpetrators in Sierra Leone. Due to the high cost of legal services in Sierra Leone, without additional program funding, WHI is unlikely to promote increased prosecutions and convictions of trafficking-related offenses. Still, the TIP-RC Project may make a dent in these problems if WHI focuses more intensely on developing stronger partnerships with legal service providers and other human rights groups in Sierra Leone.

In fact, there is clear evidence that WHI has a strong ability to build collaborative relationships with partner organizations and then use these relationships to effectively address implementation issues. One of their biggest challenges has been addressing problems caused by implementing partners' lack of consistency in following policies established by the TIP National Task Force. TIP-RC staff members have used their strong relationships with partner organizations to persistently address these problems, while advocating for trafficking victims and teaching other organizations about appropriate child and victim protection practices. This approach has worked quite well in the Sierra Leone context. Indeed, all interviewed partner organizations reported having an excellent relationship with WHI, while also stating that the TIP-RC Project has significantly improved the protection of VoT in Sierra Leone. Therefore, WHI should be encouraged to leverage its relationship building skills to increase its collaborative partnerships with legal organizations in order to better address their clients' legal needs.

4.2 REFERRAL AND SCREENING PROCEDURES

Both the referral and screening procedures at the TIP-RC are very strong and are in compliance with best practices from the victim identification literature (IOM, 2007; Macy & Graham, 2012). Yet, a unique feature of these processes is that they are built on the foundation developed from

WHI's TIP Prevention Program as well as their well-established collaborative relationships with partner organizations in Sierra Leone. WHI conducted TIP-related trainings in Sierra Leone for several years before the onset of the TIP-RC Project, and the shelter began as a natural consequence of the increased identification of VoT as a result of their TIP Prevention Program. The TIP-related trainings provided by the TIP-RC Project are based on the resources and connections developed from the earlier TIP Prevention Program. In fact, it was difficult for WHI staff members to differentiate between TIP trainings funded by the two different programs. Still, there is evidence that the TIP-related trainings from the TIP-RC Project, in addition to WHI's strong focus on relationship building with partner organizations, have improved the ability of the GOSL and other organizations to accurately identify and refer VoT to the shelter. Also, WHI's efforts (i.e., the development of the TIP Assessment Tool, the TIP-related trainings, and their involvement on the TIP National Task Force) have helped the GOSL to strengthen the national referral mechanism, increasing the likelihood that child trafficking victims in Sierra Leone are being systematically identified, protected, and supported in their recovery process. These would not have been accomplished without WHI's persistence in advocating for VoT and their strong focus on training and collaborating with partner organizations. Yet, this is still a work in progress, and WHI should continue advocating and training on TIP issues to further improve accurate victim identification and the consistent use of the TIP national referral mechanism.

4.3 REINTEGRATION SUPPORT SERVICES

Reintegration support services are necessary to help trafficking victims re-enter normal community life with independent and adaptive functioning (Arensen et al., 2004; Muco, 2013; Surtees, 2013), which is the end goal of most trafficking victim assistance programs. Overall, the reintegration support services provided by the TIP-RC Project generally comply with recommended practices in the aftercare service delivery literature (IOM, 2007; Muraya & Fry, 2016). These services generally strengthen the program model and contribute to successful reintegration outcomes, even though there are some weaknesses present in their current service delivery model. In general, TIP-RC staff members adequately assess and prepare clients, families, and communities for reintegration. They show strength in their ability to thoroughly assess, identify, and address the relevant protective factors and risk factors for reintegration, even though this could be further strengthened by incorporating additional data-based decision making practices (see Section 4.4). WHI has adapted best practices to the African context by including community stakeholders in both the assessment process and during reunification procedures, while maintaining key elements of client confidentiality (i.e., not sharing the purpose of their exploitation). The TIP-RC service delivery model also includes generally adequate post-reintegration monitoring practices, although they are not currently in compliance with the recommended best practices regarding the frequency of monitoring visits (IOM, 2007). The TIP-RC makes up for some of this deficiency by utilizing implementing partners and other supportive community members to monitor reintegrated clients. Plus, when they do conduct community-based follow-up visits, they are comprehensive and thorough, allowing them to be responsive to their reintegrated clients' needs.

Overall, the TIP-RC's reintegration support services are comprehensive. They are not disregarding any essential practices that could help improve their clients' functioning post-reintegration, but instead, the weaknesses in their current service delivery model generally

involve not providing sufficient levels of some of these services, as recommended in the aftercare service delivery literature (IOM, 2007; Muraya & Fry, 2016). The main weaknesses in their reintegration support services include: (a) not providing enough family bonding visits; (b) not sufficiently resourcing or supporting families to make their income generating projects sustainable; and (c) conducting fewer community-based follow-up visits for reintegrated clients than recommended. Key informants at WHI acknowledge these problems, stating that they would like to be in full compliance with international best practices. However, they cannot afford to do this given their current staffing levels and funding limitations. Therefore, their current service delivery model tries to balance the needs of their reintegrated clientele, while also operating within certain financial limitations. As will be discussed in Section 4.6, this compromised practice has not generally interfered with the TIP-RC's ability to obtain positive reintegration outcomes, except for the outcomes related to the income generating projects.

4.4 STAFF CAPACITY OUTCOMES

One of the significant difficulties of operating victim assistance programs in low resourced countries is that there are few professionally trained and qualified service providers. Low resourced countries usually lack a well-develop social service system and generally have few, if any, graduate-level training programs in the human service fields. This was the problem that WHI faced in Sierra Leone. Because the provision of high quality aftercare services is a labor intensive process, requiring highly skilled service providers, WHI addressed this implementation issue by: (a) hiring Sierra Leonean staff members with the appropriate soft qualities to be competent caregivers; (b) employing an expatriate staff member with the appropriate clinical credentials to fill the TCPS/clinical supervisor role; and (c) providing on-going training and clinical supervision to all staff members throughout the course of the project. These efforts have paid off because there is ample evidence from this evaluation to indicate that WHI has developed the professional capacity of the TIP-RC staff members to generally competent levels in several domains, including: (a) providing trauma-informed care; (b) developing and implementing appropriate treatment plans and reintegration plans; (c) engaging in several aspects of data-based decision making; and (d) managing job-related stress via organizational support and some use of self-care practices.

One of the greatest strengths of the TIP-RC staff is their ability to provide a high level of trauma-informed care, which is a strongly recommended service delivery practice for trafficking victim assistance programs (Clawson et al., 2008; Johnson, 2012; Macy & Johns, 2011; Muraya & Fry, 2016; Zimmerman & Borland, 2009). In general, staff members, especially the clinical staff members, understand the effects of trauma on clients and try to build healthy therapeutic relationships with the residential clients. Moreover, the care provided at the TIP-RC emphasizes trauma recovery and client empowerment. However, staff members showed a weakness in being able to fully utilize trauma-informed practices to manage externalizing problems in residential clients, including physical and verbal aggression. Not all TIP-RC clients are admitted to residential care with externalizing problems, but for highly symptomatic clients, the TIP-RC staff members struggle with managing and reducing their hostility and aggression. Although the relational approach utilized by the staff members to intervene with dysregulated clients is not likely to re-traumatize them or impede their recovery process, it is also not very effective in reducing externalizing behaviors. Based on recommendations in the trauma-informed care

literature (Elliot et al., 2005), WHI should start to address this problem by requiring all clients to have an individualized safety or crisis management plan that includes identified triggers and preferred de-escalation strategies based on client feedback. Additionally, WHI should train staff members to develop and apply individualized behavior modification programs in the residential milieu with the most highly symptomatic clients, which could reduce some of their emotional and behavioral dysregulation while in residential care.

Based on the evidence available, the chart reviews indicated that the TIP-RC clinical staff members are generally developing and implementing appropriate treatment plans and reintegration plans, which are in line with the recommendations in the aftercare service delivery literature (see Clawson et al., 2008; Macy & Johns, 2011; Muraya & Fry, 2016; Williamson et al., 2010). In comparison to the 2013 TIP-RC Evaluation (Barnett, 2013), the clinical staff members have grown significantly in their ability to independently conceptualize cases, plan interventions, and provide peer supervision during the case management team meetings, which is indicative of a higher level of staff capacity. In addition, the clinical staff members are effectively using data to identify problems and develop interventions, but they are not adequately using data to monitor intervention effectiveness at both an individual and a programmatic level. Some of these limitations could be overcome with some additional training and new operating procedures (e.g., making sure the midpoint CCAT is consistently administered, and requiring the discussion of the CCAT and PRAT findings in case management team meetings before making reintegration and discharge decisions). However, based on the lack of treatment outcomes or reintegration outcomes reported in the aftercare service delivery literature (Muraya & Fry, 2016; Potocky, 2010; Rafferty, 2013), the TIP-RC probably utilizes data-based decision making more consistently than is standard practice in most victim assistance programs. Nevertheless, their record keeping practices (both for case files and data-based decision making) are problematic in that they do not comply with WHI policy and they are below acceptable professional standards for countries with a well-developed social service field. In order to improve documentation, there is a need for the current record keeping practices to be streamlined and administration needs to hold clinical staff members accountable for not following documentation policies.

Overall, WHI should be commended for its effectiveness in building competent levels of staff capacity during the course of the TIP-RC Project, regardless of the need for additional staff development. Moreover, WHI has adequately supported and retained staff members in a field typically associated with burn-out and high staff turnover. Because the provision of quality and effective care is linked to employing highly-skilled service providers, it is doubtful that the TIP-RC Project would have obtained generally positive client outcomes (which will be discussed in the next two sections) without their investment of resources in building the professional capacity of the TIP-RC staff.

4.5 STABILIZATION AND RECOVERY OUTCOMES

Based on the evidence available, the TIP-RC has generally been effective in stabilizing and recovering VoT over a broad range of comorbid problems during the course of residential care. The comprehensive aftercare services have had beneficial effects on significantly improving the following areas for the clientele: (a) physical health problems; (b) some mental health symptoms (i.e., trauma-related symptoms and internalizing problems); (c) coping skills; (d) self-confidence;

and (e) self-protection skills. Clients also showed significant improvements in their academic and/or vocational functioning while in the shelter, even though these improvements were not as substantial as the other domains. The two greatest reported problem areas for clients at admission (i.e., trauma-related symptoms and inadequate self-protection skills) showed the greatest improvements by the midpoint of residential care, indicating that the treatment provided at the TIP-RC is targeting and effectively addressing the most relevant identified problems in its clientele. Overall, WHI believes that comprehensive services are needed to address the broad range of comorbid problems that they encounter in VoT, which is in line with the recommended practices espoused by the aftercare service delivery literature (IOM, 2006; Macy & Johns, 2011; Muraya & Fry, 2016; Surtees, 2013; Zimmerman et al., 2006) and is supported by a program evaluation of another trafficking victim assistance program (Potocky, 2010). It is likely that the improvements seen in the residential clients, over a wide range of psychosocial domains, during the course of residential care is due to their provision of comprehensive services.

No improvements were identified in the clients' ability to utilize spiritual resources as a means to cope with stressors. However, this is not unexpected given that this seems to be an area of strength for the majority of the clients when they enter the shelter. Since WHI is a faith-based organization and spirituality is quite salient in the Sierra Leone context, TIP-RC staff members generally support clients' engagement in spiritual practices during residential care, while respecting religious differences. In order to foster the development of this strength, the TIP-RC staff members should intentionally encourage clients, who identify as religious, to utilize their relevant spiritual resources (e.g., praying) as coping skills.

The TIP-RC clients generally reported only small, yet non-significant improvements in mental health symptoms related to externalizing problems (i.e., hostility) and prosocial behaviors. These results are particularly troubling given that there is preliminary evidence from other studies (Brunovski & Surtees 2012; Reimer et al., 2007), as well as the qualitative data from this evaluation, that these problem areas are associated with negative reintegration outcomes. In addition, results regarding the lack of significant improvement in externalizing problems are substantiated by other findings from this report, such as (a) staff members reporting that one of the most stressful parts of their job involves managing residential clients' verbal and physical aggression; (b) several staff members requesting the shelter utilize more culturally appropriate, yet non-punitive disciplinary practices, instead of the primarily relational approach currently utilized; and (c) staff members demonstrating insufficient expertise in utilizing intervention strategies for externalizing problems. Because there is substantial comorbidity between externalizing problems and prosocial behaviors in this sample, it would seem wise for WHI to initially focus on improving staff members' ability to manage aggression and to utilize evidence-based interventions to reduce externalizing problems.

However, it is interesting to note that hostility in the clients is related to an increased ability to use self-protection skills. Thus, hostility and aggression seem to be adaptive behaviors and may be one of the few ways that child trafficking victims have learned to protect themselves from additional exploitation and abuse. VoT are not likely to show reductions in their externalizing behaviors until they feel safe and have explicitly learned more functional ways to protect themselves. It is also a possibility that some of the TIP-RC clients may remain partially entrenched in hostile behaviors because they do not feel safe enough to drop these adaptive, yet

defensive behaviors in a society that generally shows impunity to their perpetrators. It would be interesting to see if the TIP-RC's clients showed greater reductions in externalizing behaviors if the legal support provided by the TIP-RC was more effective in bringing TIP perpetrators to justice.

Another finding was that both older clients and clients with longer trafficking-related experiences tended to be more symptomatic and distressed when admitted to the shelter. They also tended to spend more time in residential care before reintegration, which is probably due to their higher rates of distress at admission. In fact, clients with more trauma-related symptoms, more internalizing problems, and poorer coping skills when they entered the TIP-RC also tended to spend more time in residential care. It makes sense that it would take longer to stabilize clients who are admitted with more mental health symptoms and poorer psychosocial functioning. These findings support the TIP-RC's practice of providing residential care for a flexible length of time, depending on clients' needs, as well as assessing clients for reintegration readiness before developing reintegration plans.

4.6 REINTEGRATION OUTCOMES

Based on the evidence available, the TIP-RC Project has been somewhat effective in successfully reintegrating VoT in the Sierra Leone community, even though these results are mixed. However, it is impossible to make definitive statements about their reintegration outcomes because (a) the data analyses were exploratory due to the factors discussed in Section 3.6, and (b) there are no established norms regarding reintegration outcomes for trafficking victim assistance programs.

It has been suggested that losing contact with clients should be considered a primary outcome of program evaluations for child trafficking assistance programs (Gibbs et al., 2015). The TIP-RC reported only losing contact with 3% of their reintegrated clients (before discharge from the program) over the course of the entire project, which is significantly better than the 15%-51% rates reported in the Gibbs et al. program evaluation of three American community-based victim assistance programs. This is a noteworthy finding given the fact that the TIP-RC has to maintain contact with reintegrated clients across the entire country of Sierra Leone and not all reintegrated clients have access to phone service. This suggests that the TIP-RC is diligent in monitoring clients after reintegration, regardless of the frequency of community-based follow-up visits. This finding also indicates that probably few reintegrated clients have been re-trafficked during the standard 12-month follow-up period after reintegration.

The majority of the TIP-RC clients demonstrated good reintegration outcomes (i.e., low rates of mental symptoms and few problems related to psychosocial functioning) approximately 8 months after reintegration into normal Sierra Leone community life. In particular, a substantial percentage of reintegrated clients (88%-100%) showed: (a) low levels of exploitation risk factors related to physical health and community risk factors; (b) high levels of family acceptance and support; and (e) high levels of community acceptance after reintegration. Yet, moderate to high rates of family risk factors were identified for 25% of the reintegrated clients, whereas 39% of the reintegrated clients showed moderate to high rates of poor educational or vocational functioning after being reintegrated for approximately 8 months. The findings for psychosocial

adjustment following reintegration were quite variable. A substantial percentage of reintegrated clients (88%-100%) showed high levels of psychosocial adjustment in regards to externalizing symptoms, prosocial behaviors, self-confidence, spiritual resources, and coping skills. In fact, utilizing coping skills to manage on-going psychosocial problems seems to be the area where reintegrated clients showed very little decline in functioning after reintegration, indicating that the coping skills learned in the shelter were also used in regular community life. Yet, between 24%-35% of all reintegrated clients demonstrated moderate to high rates of trauma-related symptoms, internalizing problems, and inadequate self-protection skills. Reintegrated clients also showed significantly increased symptomatology in these areas from the time they left the shelter until approximately 8 months after reintegration, indicating that they experienced more psychological distress and poorer psychosocial functioning in these areas once they were living in normal Sierra Leone community life in comparison to residential care.

These results are similar to findings from the Youth Readiness Intervention, which was an evidenced-based 10-week group intervention for distressed, war affected youth in Sierra Leone (Betancourt, McBain, Newnham, et al., 2014). They found that the intervention had significant improvements in emotion regulation, prosocial behavior, social support, and functional impairments immediately after completing the intervention, but it was not associated with significant reductions in psychological distress or PTSD symptoms. Moreover, the improvements in all areas of psychosocial functioning at post-intervention were not maintained at the 6-month follow-up. "Given the role of daily stressors in influencing psychological distress and as documented in prior research in the region, it is possible that reductions in distress may not be seen unless concurrent reductions in daily stressors and increases in economic security are evident" (Betancourt, McBain, Newnham, et al., 2014, p. 1295). Essentially, daily life in Sierra Leone, like other low resourced countries, is generally difficult and marked by high rates of economic insecurity. As a result, reintegration outcomes need to take these realities into consideration. It also emphasizes the importance of substantially stabilizing trafficking victims – through the provision of comprehensive aftercare services – before reintegrating them in low resourced countries because their psychosocial adjustment will most likely be negatively affected by post-reintegration contextual factors that are often inherent in these societies.

Also, these findings support the need for aftercare programs to offer comprehensive reintegration support services, especially in regards to regular monitoring practices. The reintegration process is difficult, especially in low resourced countries, and VoT need adequate support services after reintegration to successfully navigate the challenges related to obtaining independent and adaptive functioning in normal community life. Although the TIP-RC monitors reintegrated clients via phone calls and community-based follow-up visits, its current monitoring practices are not at the level recommended by the IOM (2007) due to staffing limitations. Most likely, this will not change without additional funding; therefore, WHI is encouraged to develop relationships with additional partner organizations that can assist with providing follow-up support to reintegrated clients.

Although the TIP-RC Project obtained relatively positive reintegration outcomes, improving their reintegration support packages is likely to have the biggest impact on further improving their reintegration outcomes. Based on research findings (Betancourt, McBain, Newnham, et al., 2014; Brunovski & Surtees, 2012; Surtees, 2013) and qualitative data from this evaluation, it is

likely that some of the poor reintegration outcomes for family risk factors, educational functioning (due to being unable to pay for school fees), and psychosocial adjustment could be related to the high rates of economic insecurity in the post-reintegration families. Due to the pervasiveness of poverty in Sierra Leone, there are significant limitations to WHI's ability to improve the economic security of post-reintegration families. However, the reintegration support packages, especially the income generating projects, are not sufficient to begin to address this problem because the income generating projects are too small and family members are not adequately equipped to manage their projects. Finding creative ways to improve the quality of the reintegration support packages is the most important thing that WHI can do to further improve their positive reintegration outcomes.

The TIP-RC's lower rates of positive reintegration outcomes for educational and vocational functioning could also be related to factors inherent in a low resourced country (e.g., the severe lack of viable employment and educational opportunities). Yet, WHI did not make sufficient progress in addressing the recommendations to improve the shelter's vocational services from the 2013 TIP-RC Evaluation (Barnett, 2013), nor did they replace the Vocational Coordinator when the position opened up. Although the vocational services are not as important for younger clients who will be financial dependent on their caregivers, older clients, especially ones with limited education, need adequate vocational skills to improve their ability to be economically secure after reintegration. Therefore, improving the vocational services offered at the shelter could have a positive effect on their clients' vocational functioning after reintegration, which could also help improve their likelihood of being self-sufficient and free of exploitation in the future.

5.0 RECOMMENDATIONS

In light of the information covered, this evaluation's overarching recommendation is to continue the TIP-RC Project due to its successful results in a challenging environment. This section assumes that there is little feasibility in increasing program funding; therefore, the specific recommendations include only action items that are either feasible under the TIP-RC's current funding level or necessary to obtain program goals. Thus, the following recommendations are offered to WHI to improve the model of services at the TIP-RC:

1. **Develop a Sustainability Plan:** It is recommended that WHI develop a plan to obtain sustainable funding for the TIP-RC Project. This plan should include specific ways to obtain funding from the GOSL and international donors. In addition, they need to develop ways to increase funding through WHI's donor base. They are encouraged to utilize program outcomes from this evaluation and their future data-based decision making practices to substantiate their funding requests.

2. **Improve Record Keeping:** TIP-RC staff members need to improve their ability to document all clinical services in a timely fashion, as per WHI policy. It is recommended that the Shelter Manager and TCPS review, update, and streamline all documentation policies based on current acceptable practices at the TIP-RC. These policies should also include the expected timeframes for administering and documenting all client outcome data (e.g., CCAT and PRAT). It is also recommended that the TCPS: (a) streamline all TIP-RC forms (e.g., using more checked boxes, instead of narrative summaries); (b) train clinical staff members on completing assessment forms in the field; and (c) conduct monthly chart audits and hold staff members accountable for failing to maintain documentation standards as per WHI policy.

3. **Strengthen Data-Based Decision Making Practices:** TIP-RC's operating procedures should be modified to improve their ability to use data to monitor the effectiveness of interventions at both an individual and a programmatic level. It is recommended that the Shelter Manager and TCPS: (a) have the CCAT and PRAT translated from English into Krio; (b) require clinical staff members to discuss findings from the CCAT and PRAT (in addition to the other forms of assessment data currently used) in case management team meetings before making clinical decisions about reintegration or discharge; (c) track new sources of client outcome data, including clients' weight throughout the course of care (to measure physical health outcomes) and the percentage of reintegrated clients that they have lost contact with before discharge from the program (to measure client attrition outcomes); and (d) utilize an electronic spreadsheet to track all client outcome data (and the information included on the WHI Data Sheet) in order to make data analyses easier. WHI should provide administrative support to help the TIP-RC staff members to assess the outcome data, modify program interventions based on these results, and then share these results with stakeholders.

4. **Build Additional Staff Capacity:** The TIP-RC staff members need to develop additional professional capacity to reduce externalizing problems in the clientele. The TCPS should train and supervise the appropriate TIP-RC staff members on how to: (a) develop and implement individualized safety or crisis management plans for all residential clients; (b) develop and implement individualized behavior modification programs in the residential

milieu for highly symptomatic clients; and (c) utilize evidence-based interventions for externalizing problems in individual counseling sessions.

5. **Develop Additional Collaborative Partnerships:** WHI needs to prioritize the development of collaborative partnerships with local organizations that provide the following services: (a) legal aid services; (b) vocational training; (c) community-based support services for children; and (d) micro-finance and business support for the income generating projects.

6. **Improve Vocational Training:** In addition to possible support that could be provided from partnerships with vocational training organizations, the Shelter Manager should ensure that at least one of the TIP-RC House Parents can also function as the Vocational Coordinator. The Vocational Coordinator must be able to teach a marketable vocational skill for the Sierra Leone context and provide training on general business skills as well as the "soft skills" related to employment.

7. **Strengthen Reintegration Support Packages:** In addition to possible support that could be provided from partnerships with micro-finance and business support organizations, WHI should increase the size of the income generating projects, for at least the most economically insecure families. This should be paired with providing additional training to the TIP-RC Social Workers on how to develop and support effective income generating projects for these families.

8. **Continue Advocating and Training on TIP Issues:** WHI should continue advocating and training on TIP-related issues to the GOSL and partner organizations to further improve accurate victim identification and the consistent use of the TIP national referral mechanism. These activities should also be used to continue to build the capacity of the GOSL and partner organizations in utilizing appropriate child protection and victim protection practices.

6.0 LESSONS LEARNED

In light of the TIP-RC program evaluation, the following lessons learned and promising practices have been identified to inform J/TIP's decisions regarding the future design, implementation, and funding of comprehensive aftercare services for child trafficking victims:

1. It is important that program designs include strong referral services to ensure that child trafficking victims are being systematically identified and protected. Accurate victim identification and appropriate referrals are more likely to occur when programs provide outreach trainings and advocacy for TIP-related issues with government officials, law enforcement officials, and human service providers. It is also recommended that these trainings should include information about appropriate child protection practices and victim protection practices. Partnering with a TIP prevention program can further strengthen these efforts.

2. Due to the comorbidity of problems faced by child trafficking victims, it is more effective to provide comprehensive services, including residential care, physical health care, mental health care, chemical dependency treatment, education, vocational training, life skills education, and legal support. The delivery of these services should be individualized for each client based on: (a) a comprehensive client assessment at admission, and (b) regular progress monitoring during the course of care. The goal of these services should be to stabilize clients and prepare them for independent and adaptive functioning in normal community life post-reintegration.

3. The reintegration process is often challenging and difficult, especially in low resourced countries. Therefore, it is recommended that clients be sufficiently stabilized and recovered before beginning the reintegration process. This should increase the likelihood that trafficking victims obtain independent and adaptive functioning in normal community life, while minimizing the risk of future exploitation.

4. Providing comprehensive reintegration support services are also essential for obtaining positive reintegration outcomes. Better outcomes are more likely to be obtained if these services include:
    a. Thoroughly assessing clients, families, and communities for reintegration readiness using various sources of data;
    b. Identifying reintegration protective factors and risk factors for clients, families, and communities;
    c. Implementing intervention strategies to mitigate all identified risk factors before reintegration (e.g., mediating family conflicts, minimizing stigma, and providing economic assistance to post-reintegration caregivers);
    d. Utilizing alternative care placements if risk factors cannot be sufficiently reduced;
    e. Developing reintegration plans based on the best interest of the client;
    f. Preparing clients, families, and key community stakeholders for reintegration (e.g., completing family/community visits; discussing transition planning with clients; providing psychoeducation on TIP-related issues and child protection practices to families);

g. Implementing regular monitoring practices (e.g., phone calls and community-based follow-up visits) and providing any necessary post-reintegration interventions for at least 12 months after reintegration.

5. The economic security of clients and their caregivers seems to play a key role in minimizing exploitation risk factors and facilitating psychosocial adjustment in clients post-reintegration, especially in low resourced countries. Thus, it is recommended that reintegration support services include adequate economic assistance strategies, especially strategies that are designed to help families obtain a sustainable income.

6. Multidisciplinary and collaborative partnerships are usually necessary to provide high quality comprehensive aftercare services while controlling for program costs. Yet, it usually takes time and strong relationship building skills to establish these partnerships. Therefore, priority should be given to fund organizations that are well networked in a region or can demonstrate a proven track-record in establishing collaborative partnerships.

7. Program designs need to include appropriate staffing levels using professionally qualified service providers in order to ensure a high standard of care and to better obtain program goals. When programs operate in low resourced countries without a well-developed social service field, it is essential that their program designs include systematic strategies to build staff capacity. The following strategies used by the TIP-RC Project have been effective and could be replicated in other programs: (a) hiring local staff members with the appropriate soft qualities to be competent caregivers; (b) employing a staff member (who may need to be an expatriate) with the appropriate clinical credentials to fill a clinical supervisor role; and (c) providing on-going training and clinical supervision to all staff members throughout the course of the project. Staff members need to be trained and supervised on: basic caregiving skills, child protection practices, trauma-informed care, and self-care practices. Additionally, clinical staff members need to be trained on how to develop and implement appropriate treatment plans and reintegration plans. Building competent levels of staff capacity is possible, but it takes time and an investment of resources.

8. When programs operate in countries with limited affordable legal services, they will need additional funding to provide effective legal support for their clients in order to promote increased convictions of TIP perpetrators. This is even more important when programs operate in countries that have limited TIP-related prosecutions and convictions due to systemic problems in either the law enforcement sector or the judicial system.

9. Program designs should include effective monitoring and evaluation procedures. Moreover, it would be beneficial for program staff members to be trained and supervised on using data-based decision making practices. This would allow program staff members to routinely collect and analyze various forms of data to identify problems, to inform decision making about interventions, and to monitor intervention effectiveness at both a client-level and a program-level. This routine data collection should minimally involve the quantitative assessment of expected program outcomes at baseline (e.g., admission to the program), post-intervention, and follow-up.

It is important that culturally-valid measures are used; therefore, the same assessment tool cannot be used between different cultures and contexts. To measure stabilization and recovery outcomes, it is recommended that programs develop culturally relevant tools to measure the following constructs: (a) physical health symptoms; (b) mental health symptoms, including trauma-related symptoms, internalizing problems (i.e., anxiety and depression), and externalizing problems (i.e., hostility); (c) coping skills; (d) prosocial behaviors; (e) self-confidence; (e) self-protection skills; and (f) academic and/or vocational functioning. To measure reintegration outcomes, it is recommended that programs develop culturally relevant tools to measure the following constructs: (b) exploitation risk factors involving the family, community, and the clients' physical health; (c) psychosocial adjustment in reintegrated clients; (d) family acceptance and support experienced by reintegrated clients; (e) community acceptance experienced by reintegrated clients; and (f) academic or vocational functioning in reintegrated clients. Also, well-designed measures should be easy to administer and to interpret, allowing the findings from these measures to be clinically relevant to staff members. This would result in programs being able to use data at both a client-level (e.g., to inform treatment plans) and a program-level (e.g., to assess program outcomes), which should lead to more effective interventions and programs.

10. Providing high quality comprehensive aftercare services to child trafficking victims is expensive. Until more research is conducted to determine what level of aftercare services are needed to obtain successful reintegration outcomes in this population, comprehensive services should be considered the gold standard. However, due to the high costs of running a comprehensive program, it is recommended that program designs include plans to obtain long-term sustainable program funding.

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ANNEX 1: STATEMENT OF WORK

Statement of Work
For
Management Analyst
Washington, D.C.
(GS-15, Step 8 equivalent)

General Description

The Department of State's Office to Monitor and Combat Trafficking in Persons (TIP Office) leads the United States' global engagement on the fight against human trafficking, partnering with foreign governments and civil society to develop and implement effective strategies for confronting modern slavery. The Office has responsibility for bilateral and multilateral diplomacy, targeted foreign assistance, and public engagement on trafficking in persons.

The TIP Office's International Programs section funds international and nongovernmental organizations (NGO) that are strategically placed to fuel greater progress in foreign countries based on trends and needs outlined in the annual Trafficking in Persons Report (TIP Report). Project activities are generally aligned with the "3P" paradigm: protection and assistance to victims of human trafficking, prosecution of traffickers, and prevention. The section's program managers monitor funded projects and conduct site visits for on-the-ground assessments and technical assistance.

The TIP Office supports a variety of activities for addressing human trafficking and is committed to an evaluation strategy that facilitates managing foreign assistance by results. To identify the most effective models of intervention, the TIP Office has funded external on-site evaluation of selected projects to assess the soundness of the project design and program implementation, outcomes, and impact, as well as potential for scaling up or replication in other locations.

Period of Performance

An award for this evaluation is anticipated in September 2014 and the period of performance is expected to be one year because of the unprecedented outbreak of Ebola and guidance from the CDC urging all US residents to avoid nonessential travel to Sierra Leone. After the current travel warning is lifted, the successful contractor shall consult with the TIP Office regarding appropriate dates for the on-site assessment and development of the timeline for work deliverables.

Relationships

The Analyst receives direct government oversight and daily assignments from the J/TIP/RMP and J/TIP/PE evaluation specialists.

Duties/Responsibilities

<u>Writing/Analysis</u>

- Conduct a desk audit of project records; study the TIP Report country narrative for Sierra Leone; and review recent media reports on TIP in Sierra Leone.
- Consult with WHI regarding access to Recovery Center staff and activities, case records and data, and implementing partners.
- Conduct an evaluation of the services provided at the Recovery Center utilizing a methodology consistent with the 2013 evaluation that covers the following:
    - The referral and screening procedures used to identify and admit beneficiaries of the Recovery Center;
    - The role of implementing partners in the provision of services to beneficiaries; and
    - Follow up with survivors who have been reintegrated in the community or alternative placements.

The evaluation report should provide evidence-based findings that will inform the TIP Office's decisions regarding the future design, implementation, and funding of programs to provide comprehensive services for young female survivors of human trafficking.

- The evaluation final report shall include the title, date submitted, an executive summary, introduction, background of the local context and the project being evaluated, the evaluation questions, the methodology, the limitations to the evaluation, findings, conclusions, recommendations, and lessons learned. The annexes to the report shall include: all tools used in conducting the evaluation, such as questionnaires, checklists, interview guides, human subjects' protection protocol and informed consent forms; disclosure of conflicts of interest forms for all evaluation team members; and confidentiality forms.
- The Highlights of the Evaluation Report should include the title, date submitted, the evaluation questions, methodology used, key findings, and recommendations.
- Evaluation findings shall be presented as analyzed facts, evidence, and data and not be based on anecdotes, hearsay or the compilation of people's opinions. Findings should be specific, concise and supported by strong quantitative and/or qualitative evidence. Recommendations shall be supported by a specific set of findings. Recommendations should be action-oriented, practical and specific, with defined responsibility for the action.

<u>Evaluation Design and Work Plan</u>

- The contractor shall be expected to submit the evaluation design and work plan to the TIP Office for review and approval.
- The **evaluation design** shall include a detailed evaluation design matrix showing key questions along with methods, data sources, and a data analysis plan for each question; draft interview guides and other data collection instruments; and known limitations to the evaluation design.
- The **work plan** shall include the anticipated schedule for deliverables; a plan for conducting the site visit with logistical arrangements; and a plan for human subject protections.
- Qualitative and quantitative data collection shall include compilation and analysis of client characteristics and services data; analysis of interviews with staff and partner

organizations, as well as observations at the Recovery Center; a brief review of contextual factors related to the trafficking situation and anti-trafficking resources in the target area; and an analysis of case outcomes based on case records.

- Evaluation questions shall be finalized in consultation with the TIP Office; however, questions such as the following are anticipated:
    - To what extent are the previous evaluation findings citing this program as a potential "best practice" model for West Africa valid?
    - What are the key program elements that underpin this model of services?
    - How does cooperation with partner organizations contribute to this model of services for young female survivors of human trafficking?
    - How do the referral and screening procedures used to identify and admit beneficiaries of the Center contribute to or undermine implementation of this program model?
    - Did the Center follow up with survivors who have been reintegrated in the community or alternative placements? If so, what are the findings?

Site Visit

- Conduct an on-site assessment of the WHI project in Freetown, Sierra Leone, that shall achieve the purposes outlined in the Purpose section of this RFTOP, while spending approximately 12 business days on site.

Oral Briefings

- The contractor should have at minimum a monthly briefing with the TIP Office reviewing progress and determining next steps.
- An oral briefing is due following submission of the final report and the final highlights report that address comments from the TIP Office.

12-Month Deliverable Matrix

Month	Deliverable	Hours Expected
September	Kick-Off meeting	1
October	Project document review and monthly check-in meeting	19
November	Project document review and monthly check-in meeting	19
December	Development of on-site evaluation plan, monthly check-in meeting	26
January	Development of on-site evaluation plan, monthly check-in meeting	26
February	Preparation of Tools, monthly check-in meeting	26
March	Preparation of Tools, monthly check-in meeting	26
April	Planning on-site interviews, monthly check-in meeting	26
May	Travel preparation and monthly check-in meetings	26
June	Travel to Sierra Leone for on-site visit[1] and monthly meeting	145
July	Compilation and analysis of data, production of draft	146

[1] May be adjusted based on travel guidance provided by the Department of State.

	report and highlights document and monthly meeting	
August	Final report, final highlights document, and oral briefing to close out contract	120
Total		**606**

Minimum Qualifications

- U.S. Citizenship
- Minimum five years of experience at an equal level
- Ability to communicate effectively orally and in writing
- Ability to establish and maintain effective relationships
- Familiarity with the topic of human trafficking
- Experience working in field of psycho-social services
- Experience with conducting program evaluation

Government Furnished Equipment

The Department of State will not provide any equipment for this project. The TIP Office will coordinate all contacts with the U.S. Embassy in Freetown. The U.S. Embassy is not expected to provide logistical support for this project.

Supplemental Hours

The TIP Office expects this position will require additional hours outside of the standard CONUS (or OCONUS hours, if any) as listed in the "**Position Location and Hours**" section of this Statement of Work but only during travel. An additional 35 hours should be included initially in the task order proposal.

Clearance Requirement

No security clearance is required for this position.

Position Location & Hours

The contractor's work shall primarily take place at the contractor's own facilities, except during meetings at the TIP Office in Washington, DC (either in person or via conference call), and during the on-site assessment in Freetown, Sierra Leone. Hours may be determined by the contractor in consultation with the TIP office.

Travel

Travel is required for this position. J/TIP must approve all travel prior to the commencement thereof.

ANNEX 2: DISCLOSURE OF CONFLICT OF INTEREST

Name	Keri Bassett, Ph.D.
Title	Program Evaluation Specialist
Organization	E-9 Corporation
Evaluation Position?	☒ Team Leader ☐ Team member
Task Order	SINLEC14Q0034
Project Evaluated *(Include project name and implementer name)*	Project: Trafficking in Persons – Recovery Centre Implementer: World Hope International
I have real or potential conflicts of interest to disclose.	☒ Yes ☐ No
If yes answered above, I disclose the following facts: *Real or potential conflicts of interest may include, but are not limited to:* *1. Close family member who is an employee of the operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated.* *2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation.* *3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project.* *4. Current or previous work experience or seeking employment with the operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated.* *5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated.* *6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.*	*Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project: As part of a previous evaluation of this project, this evaluator designed the assessment tools (CCAT and PRAT) used in this project to measure client symptomatology and reintegration experiences. These assessment tools are being used in the current evaluation to assess outcomes of the project.*

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	Keri Bassett, Ph.D.
Date	6/1/16

Adapted from United State Agency for International Development (2013). *Form for Disclosure of Real or Potential Conflict of Interest for USAID Evaluations.*

ANNEX 3: EVALUATION DESIGN MATRIX

Evaluation Name: Program Evaluation of World Hope International's Trafficking in Persons - Recovery Centre in Sierra Leone

Evaluation Purpose: "To provide evidence-based findings that will inform the TIP Office's decisions regarding the future design, implementation, and funding of programs to provide comprehensive services for young female survivors of human trafficking."

1. Research Question	2. Evidence or Indicators	3. Data Collection Methods	4. Data Sources	5. Data Analysis
Information related to introduction	a. WHI Organizational structure and history in Sierra Leone b. Goals and objectives c. Program logic d. Program setting e. Characteristics of staff f. Characteristics of clientele g. Types and frequency of program interventions h. Funding sources, start-up costs, and on-going cost i. Implementation issues	1. Document analysis 2. Semi-structured interviews 3. Direct observations 4. Case file analysis	1. Grant documents & progress reports; all TIP-RC policy, procedures, and forms; training materials & curriculum 2. WHI anti-trafficking technical advisor, shelter manager, trauma care & protection specialist (TCPS), 2 counselors, 2 social workers, nurse, teacher, 2 house parents 3. Shelter activities (meal, activity session,	Content analysis Descriptive statistics

1. Research Question	2. Evidence or Indicators	3. Data Collection Methods	4. Data Sources	5. Data Analysis
	j. Sustainability issues		vocational session, educational session, life skills session, first aid arts); staff meetings (management team meeting, case management team meeting, house parent meeting); social worker activities (follow-up training with police) 4. WHI Data Sheet; Case registrations forms in all case files since 10/15	
1. How does cooperation with partner organizations contribute to this model of services?	a. # and types of partner organizations b. Services provided by partner organizations in delivery model c. Types and quality of relationships developed d. # of TIP prosecutions, # of TIP convictions, # of clients making police reports, # of clients	1. Semi-structured interviews 2. Direct Observations	1. WHI anti-trafficking technical advisor, shelter manager, TCPS, 2 social workers, nurse, WHI TIP prevention director, key informants at AWC, Rainbo Initiatives, FSU, MSWGCA, WMF, and 2 VPGs 2. Social worker	Content analysis

1. Research Question	2. Evidence or Indicators	3. Data Collection Methods	4. Data Sources	5. Data Analysis
	with police investigations, # of clients with legal cases e. Types and appropriateness of legal assistance provided to clients		activities (follow-up training with police)	
2. How do referral and screening procedures used to identify and admit beneficiaries to the TIP-RC contribute to or undermine implementation of this program model?	a. Adequate TIP Assessment Tool and training curriculum on TIP identification b. # of trainings and agencies/people trained in TIP identification, # of follow-up visits c. # of referrals, referrals sources, # of referrals admitted to TIP-RC d. Adequate understanding of TIP identification and referral procedures by partner organizations e. Screening procedures adequately assesses survivor's needs and TIP status	1. Document analysis 2. Semi-structured interviews 3. Direct Observations 4. Case file analysis	1. Grant documents & progress reports; all TIP-RC policy, procedures, and forms; training materials & curriculum 2. WHI anti-trafficking technical advisor, shelter manager, TCPS, 2 social workers, WHI TIP prevention director, key informants at AWC, Rainbo Initiatives, FSU, MSWGCA, WMF, and 2 VPGs 3. Social worker activities (follow-up training with police)	Content analysis Descriptive statistics

1. Research Question	2. Evidence or Indicators	3. Data Collection Methods	4. Data Sources	5. Data Analysis
			4. Case registration forms since 10/15	
3. How do reintegration services contribute to or undermine implementation of this program model?	a. Types and appropriateness of data used to determine reintegration readiness b. Types and appropriateness of interventions used to prepare families and communities for reintegration c. Types and frequency of follow-up visits	1. Document analysis 2. Semi-structured interviews 3. Direct observations 4. Case file analysis	1. TIP-RC policy, procedures, and forms 2. TCPS, 2 counselors, 2 social workers 3. Case management team meeting 4. WHI Data Sheet	Content analysis Descriptive statistics
4. How effective has WHI been in building staff capacity at the TIP-RC?	a. High level of trauma-informed care b. Effective development and implementation of treatment plans c. Effective development and implementation of reintegration plans d. Regular use of data-based decision making	1. Semi-structured interviews 2. Direct observations 3. Case file analysis	1. Shelter manager, TCPS, 2 counselors, 2 social workers, nurse, teacher, 2 house parents 2. Shelter activities (meal, activity session, vocational session, educational session, life skills session, first aid arts); staff meetings (management team	Content analysis Descriptive statistics

1. Research Question	2. Evidence or Indicators	3. Data Collection Methods	4. Data Sources	5. Data Analysis
	e. Regular use of staff self-care practices		meeting, case management team meeting, house parent meeting); social worker activities (follow-up training with police) 3. Chart review of 8 random case files since 10/15 (5 reintegrated clients and 3 clients currently in residential care)	
5. How effective has the TIP-RC been in achieving stabilization and recovery of survivors?	a. Reduced physical health symptoms b. Reduced mental health symptoms c. Improved coping skills d. Improved prosocial behaviors e. Improved self-confidence f. Improved self-protection skills g. Improved academic/vocational functioning	Case file analysis	CCAT (baseline, midpoint, endpoint administrations): a. Physical health scale b. Trauma scale; anxiety & depression scale; hostility scale c. Coping skills scale; d. Prosocial behaviors scale; e. Confidence scale; f. Self-protection skills scale; g. Educational/ vocational functioning	Descriptive statistics; inter-item reliability; correlations; paired-samples t-tests; effect sizes

1. Research Question	2. Evidence or Indicators	3. Data Collection Methods	4. Data Sources	5. Data Analysis
	h. Improved spiritual resources		scale; h. Spirituality scale	
6. How effective has the TIP-RC been in achieving successful reintegration of survivors in the Sierra Leone community?	a. # of reintegrated survivors TIP-RC lost contact with before discharge from program b. # of reintegrated survivors in communities with VPGs or Word Made Flesh c. Low level of exploitation risk factors d. Positive psychosocial adjustment e. High level of family acceptance and support f. High level of community acceptance g. High level of academic or vocational functioning	Case file analysis	a. WHI Data Sheet b. Case file analysis PRAT: c. Physical health scale; family risk factors scale; community risk factors scale; d. Trauma scale; anxiety & depression scale; hostility scale; coping skills scale; self-protection scale; prosocial behavior scale; confidence scale; spirituality scale; e. Family acceptance & support scale; f. Community acceptance scale g. Education/vocational functioning scale	Descriptive statistics; inter-item reliability; correlations; paired-samples t-test (for scales that overlap between CCAT endpoint administration and PRAT); effect sizes; cross-tabulations (categorization based on pre-determined criteria)

ANNEX 4: INTERVIEW GUIDE

Characteristics of the Program:

1. Briefly describe the goals of the TIP-RC.
2. Briefly describe the major program interventions or activities. How are these related to the program goals?
3. Describe WHI's Victims Assistance Model. How does it relate to the program goals and interventions? Are there any other models or theories that have been used in the program design?
4. Review the logic model. What feedback do you have about the logic model? Would you recommend any changes?
5. In what ways does the TIP-RC complement or fit in with the Sierra Leone culture and value system? Does it challenge common Sierra Leone cultural practices? If so, how?
6. Describe the current composition of the TIP-RC staff. What are the average caseloads of the staff members?
7. Describe the challenges of recruiting, training, and retaining quality staff members.
8. What training or supervision is offered to staff members?
9. In your opinion, what is the current level of staff capacity to accomplish program goals?
10. In what ways does the TIP-RC utilize a team approach? How does this benefit the quality of the services?
11. What are the intake criteria for the TIP-RC? What must be present for a person to be admitted to the RC?
12. Describe common presenting issues of the clients.

Implementation Issues

1. Briefly describe the history of WHI's work in Sierra Leone, especially in regards to anti-trafficking work. What role did this play in establishing the TIP-RC? What role does it play in the TIP-RC's on-going operations?
2. Describe the organizational structure of WHI and how it relates to the operation of the RC.
3. What implementation issues were faced during the course of the project?
4. How were these implementations issues addressed? What still needs to be addressed?
5. What progress has been made towards addressing the recommendations from the 2013 evaluation?

Sustainability

1. How much were the start-up costs for the RC? What are the on-going costs to run the program? How is the program currently being funded?
2. To what extent are the RC project results (impact and outcomes) likely to continue after the project ends?
3. Is there a commitment from the government of Sierra Leone, donors, or other funding sources to help sustain the project beyond Sept. 30, 2016?
4. What have been the major factors in contributing (or not contributing) to the TIP-RC's sustainability beyond the life of the J/TIP grant?

Partnerships & Referrals (WHI):

1. Describe what partnerships or relationships have been developed with implementing partners. What role do these organizations play in the TIP-RC's delivery service model?
2. What other partnership would you like to develop?
3. What are some of the challenges of working with other organizations? How have you coped with these challenges?
4. What role does WHI play on the TIP National Task Force? Has your role on this task force helped you accomplish the goals of the TIP-RC? If so, how?
5. Describe the training you provide to other organization on TIP identification. What other outreach or training do you provide on human trafficking to other organizations?
6. How has this improved the referral mechanisms in Sierra Leone? What additional training or outreach is needed?
7. Describe what challenges you see in your major referral sources ability to identify victims of human trafficking.
8. Describe the procedures other organizations should follow when they refer a case to the TIP-RC. What problems are you encountering in their ability to follow these procedures?
9. Describe how you respond to these referrals.
10. How do you screen potential clients to determine if they meet the admission criteria for the TIP-RC? What would you need to see or assess before admitting a potential client to the TIP-RC?
11. What challenges have you encountered when screening referred cases? How do you cope with these challenges?

Partnerships & Referrals (Implementing Partners):

1. Describe the type of work your organization provides. What services does your organization provide to the TIP-RC?
2. Describe the partnership or relationship you have developed with the TIP-RC. What changes, if any, would you make to this partnership?
3. How does your organization view WHI and the TIP-RC?
4. What role does the TIP-RC play in fulfilling the mission and vision of your organization?
5. What are the benefits of working with the TIP-RC?
6. What are some of the challenges of working with the TIP-RC? How have you coped with these challenges?
7. What role does WHI play on the TIP National Task Force? Has this impacted the prevention, protection, and prosecution of trafficking issues in Sierra Leone? If so, how?
8. How many potential victims of trafficking did your organization refer to the TIP-RC since October 1?
9. Describe how you would identify a victim of human trafficking. What would you need to see or assess before considering referring them to the TIP-RC?
10. Describe the procedures you would follow when you refer a case to the TIP-RC.
11. Describe what type of follow-up work your organization would do after referring a case to the TIP-RC.
12. What other health and human services are available in Sierra Leone to address the needs of trafficking survivors? Do you refer identified victims of trafficking to these other organizations?

Village Parent Group:

1. In what ways is human trafficking a problem in your community?
2. What are community attitudes towards human trafficking?
3. Describe what type of work your VPG does in your community. In your opinion, what impact has your VPG had on your community?
4. What is your opinion of the TIP-RC?
5. What are the benefits of having the services provided by the TIP-RC? Are there any negative aspects?
6. How many victims of trafficking have you identified since your VPG was started? How many potential victims of trafficking has your VPG referred to the TIP-RC since last October 1?
7. What would you do with these victims before the TIP-RC was started? What other health and human services are available in Sierra Leone to address the needs of trafficking survivors?
8. Describe how you would identify a victim of human trafficking. What would you need to see or assess before considering referring them to the TIP-RC?
9. Describe the procedures you would follow when you refer a case to the TIP-RC.
10. Describe what type of follow-up work your VPG would do after referring a case to the TIP-RC.
11. What support has your VPG provided to the TIP-RC in educating police, government workers, or community leaders about the identification of trafficking victims?
12. What support has your VPG provided to any TIP-RC clients who have legal cases?
13. What are community attitudes towards reintegration? What stigma exists towards victims of human trafficking?
14. Describe what a successful reintegration into the community looks like. In your opinion, what factors make a successful reintegration more likely?
15. How many TIP-RC clients have been reintegrated into your community? Describe the VPG's role in facilitating their reintegration into the community. In your opinion, what role does this play in improving the outcomes of reintegration?
16. What challenges have you faced in helping TIP-RC clients successfully reintegrate in your community? How have you coped with these challenges?
17. In your opinion, how effective is the TIP-RC in preparing clients, families, and the community for reintegration?
18. What additional actions or activities need to occur by the TIP-RC or your VPG in order to improve the reintegration process?

Ministry of Social Welfare:

1. Has the trainings provided by WHI enhanced the capacity of social workers/field staff to identify and protect victims of human trafficking? Has it helped enhance the capacity of social workers/field staff to provide case management to human trafficking victims? If so, how?
2. How many reports and/or complaints have been received by the Ministry of Social Welfare regarding allegations of human trafficking since last October 1? How many cases of human trafficking were identified by your field staff since October 1? Of these reports or complaints, how many involved victims who the Recovery Center staff was helping?

3. To what extent, is the Ministry of Social Welfare invested in supporting the on-going operations of the TIP-RC? Is there a commitment from the Ministry of Social Welfare or the government of Sierra Leone to help sustain the project beyond Sept. 30, 2016?

Law Enforcement:

1. Has the trainings provided by WHI enhanced the capacity of the police to identify and protect victims of human trafficking? Has it helped enhance the capacity of the police to investigate human trafficking-related cases? If so, how?
2. How many investigations of human trafficking have the police conducted since last October 1? How many of these cases involved victims who the TIP-RC staff was helping or trying to help?
3. How many individuals did police refer for prosecution for trafficking-related crimes in Sierra Leone since October 1 last year? How many of these cases involved victims who the Recovery Center staff was helping or trying to help? How many of these victims gave evidence for the prosecution?
4. (The police may not know about prosecutions). How many individuals were prosecuted for trafficking-related crimes in Sierra Leone since October 1 last year? How many of these cases involved victims who the TIP-RC staff was helping or trying to help? How many of the victims in these cases testified in court? Who helped the victims to prepare for court or to get to court?
5. Can you tell me how many individuals were convicted of trafficking-related crimes in Sierra Leone since October 1 last year? How many of these cases involved victims who the TIP-RC staff was helping or trying to help? How many of the victims in these cases testified in court? Who helped the victims to prepare for court or to get to court?

Legal Assistance:

1. How does the TIP-RC try to increase clients' access to the justice system?
2. What challenges exist in increasing and improving human trafficking prosecutions in Sierra Leone?
3. What legal services are available in Sierra Leone that can help increase and improve human trafficking prosecutions? What type of relationship or partnership has the TIP-RC developed with these service providers?
4. What assistance has been provided to the victims who have criminal cases pending (i.e., during police and/or prosecutor interviews, in preparation for testimony, during court proceedings, and after court proceedings)?
5. How many victims have made a report and/or complaint or given a statement to the police since October 1st last year? And how many have a criminal case under investigation now? How many are involved in a case that is being prosecuted? How many have a civil case pending? How many prefer to do nothing – seek no recourse through court or other means?
6. How many of these victims have pursued 'justice' through other means, such as financial compensation from someone responsible for their trafficking situation, i.e., a trafficker?
7. How many prefer to do nothing – seek no recourse through court or other means? In your opinion, why do you think these victims have pursued this course? 1. Believes Sierra Leone's justice system is not fair. 2. Faster remedy. 3. Mostly needs the funds for self and/or family. 4. Fear of giving testimony in court. 5. Other reason.

Reintegration:

1. What criteria are used to determine if a client is ready for reintegration? How is this information obtained?
2. How important is it for clients to demonstrated stabilization and recovery before they are reintegrated?
3. Describe what a stabilized and recovered client looks like before reintegration. In your opinion, what percentage of your clients demonstrates these characteristics when they are reintegrated in the community?
4. What criteria are used to determine if the family and community are ready for reintegration? How is this information obtained?
5. What challenges have you encountered when assessing clients, families, and communities for reintegration readiness? How do you cope with these challenges?
6. What do you do to prepare clients for reintegration?
7. What do you do to prepare families and communities for reintegration?
8. What challenges have you encountered when preparing clients, families, and communities for reintegration? How do you cope with these challenges?
9. What resources or services in the community do you use to increase the likelihood of successful reintegration? What role does this play in improving the outcomes of reintegration?
10. How often do you follow-up with reintegrated clients? When following up with reintegrated clients, what do you typically do? What are you looking for?
11. What are common problems you have identified through follow-up? What have you done to intervene in these problems?
12. What challenges have you encountered when doing follow-up? How do you cope with these challenges?
13. Describe what a successful reintegration into the community looks like. In your opinion, what percentage of your clients demonstrates these characteristics at the 12-month follow-up visit?
14. Using the following scale (1 = not beneficial; 2 = somewhat beneficial; 3 = very beneficial; 4 = extremely beneficial), rate how beneficial or useful the following services are in contributing (a) to the stabilization and recovery of clients before reintegration, and (b) to the successful reintegration of survivors in the community: Residential care, medical care, health education, individual counseling, group counseling, psychoeducation and life skills training, educational services, vocational training, social and recreational activities, family tracing, pre-reintegration family visits, client assessments, family assessments of reintegration readiness, community assessment of reintegration readiness, family mediation, family education on TIP and child protection issues, community outreach and education on TIP and child protection issues, financial support packages, weekly monitoring phone calls, quarterly community-based monitoring visits, legal support
15. In your opinion, are the clients receiving an adequate amount and quality of services to achieve the desired program goals?
16. In your opinion, what other factors contribute to the stabilization and recovery of clients before reintegration?
17. In your opinion, what other factors contribute to successful reintegration in the community?

Trauma-informed Care:

1. What information do you give clients about what services or activities you are going to provide them with? How much choice does each client have in the services you provide them?
2. Describe the type of relationship you try to develop with the clients? Do you maintain professional boundaries when interacting with the clients? If so, how?
3. In your professional role, do you assess client's strengths and skills? Do you help them develop their strengths or build additional skills? If so, how?
4. Does each client have a safety or crisis management plan? How would you handle a client that was behaviorally or emotionally out-of-control?
5. Do you assess clients for trauma exposure and trauma-related symptoms? If so, how?
6. What are common behavioral, emotional, and relational problems evident by the TIP-RC's clients? What do you consider to be the causes of these problems? How do you handle them?
7. How has trauma affected the clients? What are common coping strategies used by trauma survivors?
8. What training have you received on trauma? How does this trauma-related training affect how you do your job?

Self-Care Practices:

1. In your opinion, what are some of the inherent challenges when working with trafficking victims in Sierra Leone? What makes this work difficult or frustrating?
2. What training or support have you received that has helped you better cope with the demands of your job? What additional training or support would be beneficial?
3. What is the hardest part of your job? How do you cope with this?
4. Do you engage in self-care practices? If so, what do you do and how frequently do you use them?
5. Have you experienced vicarious traumatization from doing this work? If so, how do you cope with this?
6. Have these issues contributed to any staff retention issues? If so, how?

Data-based Decision Making:

1. What information or data do you collect on clients to assess clients when they are admitted to the TIP-RC? Once this assessment data is collected, do you analyze it to determine the clients' strengths and needs? If so, how?
2. Describe the process of developing a treatment plan/reintegration plan. What factors do you consider when developing this plan? How do you use assessment data to make this plan?
3. What role does assessment data play when the case management team makes a clinical decision? What other factors are considered?
4. How do you assess if a client in residential care is getting better/improving? What do you monitor to determine intervention effectiveness?
5. How do you assess if a reintegrated client is stable or adapting to community life? What do you monitor to determine reintegration success?
6. What data do you use to evaluate the outcome of your services? What have you learned about the quality of your services based on this data?

ANNEX 5: INTERVIEW GUIDE MATRIX

Interview Guide Categories	Data Sources - Interviewees
Characteristics of the Program	Shelter Manager, TCPS
Implementation Issues	Shelter Manager, TCPS, WHI Anti-Trafficking Technical Advisor
Sustainability	Shelter Manager, TCPS, WHI Anti-Trafficking Technical Advisor
Partnerships & Referrals (WHI)	Shelter Manager, TCPS, 2 Social Workers, Nurse, WHI Anti-Trafficking Technical Advisor
Partnerships & Referrals (Implementing Partners)	WHI TIP Prevention Director, key informants at Aberdeen Women's Centre, Rainbo Centre, FSU (police), Ministry of Social Welfare (MSWGCA), Word Made Flesh
Village Parent Group	2 Village Parent Group key informants
Ministry of Social Welfare	MSWGCA key informant
Law Enforcement	FSU key informant
Legal Assistance	Shelter Manager, TCPS, 1 Counselor, 1 Social Worker, WHI Anti-Trafficking Technical Advisor
Reintegration	TCPS, 2 Counselors, 2 Social Workers
Trauma-Informed Care	TCPS, 2 Counselors, 1 Social Worker, Nurse, Teacher, 2 House Parents
Self-Care Practices	Shelter Manager, TCPS, 2 Counselors, 2 Social Workers, Nurse, Teacher, 2 House Parents
Data-Based Decision Making	TCPS, 2 Counselors, 1 Social Worker

ANNEX 6: DIRECT OBSERVATIONS RECORDING SHEET

Date and time:

Staff activity:

Location and description of setting:

Please use the following scale to rate the amount of time the following characteristics were evidenced over the course of the observation period.

1	2	3	4	5	N/A
Not at all		Somewhat		All the time	Not applicable

1. To what extent was the physical environment attuned to safety, calming, and de-escalation?_____
2. To what extent did staff execute their roles and duties responsibly and professionally? _____
3. To what extent did staff use a strengths-based, positive approach in all their interactions?_____
4. To what extent did staff demonstrate empathy, respect, and unconditional positive regard in all their interactions? _____
5. To what extent did staff show evidence of having established a rapport or therapeutic relationship with participants? _____
6. To what extent did staff model healthy relationships (e.g., communication, listening skills, and conflict resolution skills)? _____
7. To what extent did staff demonstrate effective behavioral management skills when applicable? _____
8. To what extent did staff demonstrate effective emotional management skills when applicable? _____
9. To what extent did participants willingly participate and engage in the activities? _____
10. To what extent did staff function as a team as evidenced by collaboration and support? _____

Other observations:

ANNEX 7: CHART REVIEW RUBRIC

Case File #:_____
Admission date: _____ Admission Status of Case: _____

Development and Implementation of Treatment Plan

Rating	*3 = Outstanding*	*2 = Competent*	*1=Needs Development*
	Strengths & challenges were identified for the client, *and* they were logically linked to all the following: o Intake o Initial counseling sessions o CCAT	Strengths & challenges were identified for the client.	Client's strengths & challenges were *not* described in enough detail to ensure appropriate client conceptualization.
	Treatment goals were written in observable, measurable terms, *and* they were logically linked to the identified client strengths & challenges.	Treatment goals were logically linked to the identified client strengths & challenges.	Treatment goals were *not* logically linked to the identified client strengths & challenges.
	Interventions were logically linked to treatment goals, *and* were consistent with evidence-based practices.	Interventions were logically linked to treatment goals.	Interventions were *not* logically linked to treatment goals.
	Interventions included several trauma-specific practices that were individualized to client's needs based on assessment data.	Interventions included some trauma-specific practices.	Interventions did *not* include trauma-specific practices.
	Interventions included skill development strategies that were individualized to client's needs based on assessment data	Interventions included skill development strategies.	Interventions did *not* include skill development strategies.
	Acceptability of interventions by client/ guardian was verified, *and* reflected sensitivity to individual differences, resources, and other system issues.	Interventions reflected sensitivity to individual differences, resources, and other system issues.	Interventions did *not* reflect sensitivity to individual differences, resources, and other system issues.

Adapted from Hunley, S., & McNamara, K. (2010). *Tier 3 of the RTI model: Problem solving through a case study approach*. Thousand Oaks, CA: Sage and NASP.

Rating	*3 = Outstanding*	*2 = Competent*	*1=Needs Development*
	Documentation that interventions were implemented with integrity, *and* indicated client's response to interventions.	Documentation that interventions were implemented.	Interventions were *not* described in enough detail to ensure appropriate implementation.
	Strategies for changes in interventions and/or follow-up were implemented.	Suggestions for changes in interventions and/or follow-up were provided.	Suggestions for changes in interventions and/or follow-up were *not* provided.
	Documentation reported on treatment goal progress, *and* included evidence from one or more of the following: o Direct observations o Client self-report o CCAT	Documentation reported on treatment goal progress.	Treatment goal progress was *not* described in enough detail to ensure appropriate goal attainment.

Clinical observations of treatment plan section:

Development and Implementation of Reintegration Plan

Rating	*3 = Outstanding*	*2 = Competent*	*1=Needs Development*
	Assessment of client's reintegration readiness was based on all of the following: ○ Direct observations ○ Client self-report ○ CCAT	Assessment of client's reintegration readiness was based on two of the following: ○ Direct observations ○ Client self-report ○ CCAT	Client was *not* thoroughly assessed for reintegration readiness.
	Assessment of family's reintegration readiness was based on all the following: ○ Adaptive functioning ○ Relational functioning ○ Parenting ability ○ Beliefs about client & client's exploitation	Assessment of family's reintegration readiness was based on two or three of the following: ○ Adaptive functioning ○ Relational functioning ○ Parenting ability ○ Beliefs about client & client's exploitation	Family was *not* thoroughly assessed for reintegration readiness.
	Assessment of community's reintegration readiness was based on all the following: ○ Safety factors ○ Resource availability ○ Supportive community members	Assessment of community's reintegration readiness was based on two of the following: ○ Safety factors ○ Resource availability ○ Supportive community members	Community was *not* thoroughly assessed for reintegration readiness.
	The identified client, family, and community protective factors & risk factors were logically linked to the assessment data, *and* strategies were used before reintegration to mitigate risk factors.	The identified client, family, and community protective factors & risk factors were logically linked to the assessment data.	Client, family, and community protective factors & risk factors were *not* identified.
	The reintegration plan documented how it was based on the client's best interest, *and* it clearly addressed the identified protective & risk factors.	The reintegration plan documented how it was based on the client's best interest.	The reintegration plan *did not* document how it was based on the client's best interest.

Adapted from Hunley, S., & McNamara, K. (2010). *Tier 3 of the RTI model: Problem solving through a case study approach*. Thousand Oaks, CA: Sage and NASP.

Rating	*3 = Outstanding*	*2 = Competent*	*1=Needs Development*
	Family bonding occurred before reintegration via family visits and phone contact, *and* supporting evidence was provided to establish sufficient relationship building prior to reintegration.	Family bonding occurred before reintegration via family visits and phone contact.	Family bonding did *not* occur before reintegration via family visits and phone contact.
	Counseling sessions before reintegration prepared client for reintegration by addressing all the following: ○ Termination issues ○ Transition planning ○ Mitigation of client risk factors from mid-point CCAT	Counseling sessions before reintegration prepared client for reintegration by addressing one or two of the following: ○ Termination issues ○ Transition planning ○ Mitigation of client risk factors from mid-point CCAT	Counseling sessions before reintegration did *not* address any of the following: ○ Termination issues ○ Transition planning ○ Mitigation of client risk factors from mid-point CCAT
	Social worker prepared family members and several community stakeholders for reintegration via relationship building and/or education.	Social worker prepared family members and at least one community stakeholders for reintegration via relationship building and/or education.	Social workers did *not* prepare family members or community stakeholders for reintegration via relationship building and/or education.
	The reintegrated client was monitored via regular phone calls and quarterly follow-up visits, *and* supporting evidence included assessment data from the client, family, and community stakeholders.	The reintegrated client was monitored via regular phone calls and follow-up visits.	The reintegrated client was *not* monitored via regular phone calls or follow-up visits.
	Changes in the reintegration plan and/or follow-up interventions were implemented based on the assessment data from the monitoring strategies.	Suggestions for changes in the reintegration plan and/or follow-up interventions were provided based on the assessment data from the monitoring strategies.	Suggestions for changes in the reintegration plan and/or follow-up interventions were *not* provided.

Clinical observations of reintegration plan section:

Adapted from Hunley, S., & McNamara, K. (2010). *Tier 3 of the RTI model: Problem solving through a case study approach*. Thousand Oaks, CA: Sage and NASP.

Documentation

Check all documentation that is completed as per WHI policy and with adequate information to support clinical decision making:

Counselor Case File	*Social Worker Case File*
-MSWSCA Referral Form____ -Intake/Case registration Form____ -Case Management Record____ -Treatment Plan Form____ -Counseling Progress Notes: ○ Contains required elements____ ○ Required Session Frequency____ -Counselor's Telephone Record____ -Child Risk Assessment Forms____ -General Medical Intake Screen Form____ -Medical Continuation Form____ -Life Skills Training List____ -Incident Report Form____ -Baseline CCAT____ -Mid-point CCAT____ -End-point CCAT____ -PRAT____	-MSWSCA Referral Form (copy)____ -Intake/Case registration Form (copy)____ -Case Management Record____ -Social Work Progress Notes____ -Family Assessment Form____ -Community Assessment Form____ -Family & Community Risk Assessment Form____ -Reintegration Package Form____ -FTR Handover-Reunification Certificate____ -Receipt for Provided Supplies/Goods____ -Follow-up Form____

Rating	*3 = Outstanding*	*2 = Competent*	*1=Needs Development*
	100%-95% of applicable documentation is completed with adequate information	94%-85% of applicable documentation is completed with adequate information	Less than 85% of applicable documentation is completed with adequate information

Clinical observations of documentation:

Adapted from Hunley, S., & McNamara, K. (2010). *Tier 3 of the RTI model: Problem solving through a case study approach*. Thousand Oaks, CA: Sage and NASP.

ANNEX 8: CLINICAL CARE ASSESSMENT TOOL

Clinical Care Assessment Tool – Client Version

Client #: _____

Date of Administration: _____

Counselor Name: _____

Counselors: Please read each question carefully to the survivor and ask her how much she currently experiences each symptom. Mark her ***answer with an X*** according to how much she experiences each symptom (One X per question). If she does not know an answer, explain the meaning of the question to her and then re-ask her how much she experiences that symptom.

	Not applicable	Not at all	Rarely	Sometimes	Always
Trauma					
1. Do you think a lot about bad things from the past?					
2. Do you feel as though the bad things that happened in the past will happen again?					
3. Do you have bad dreams?					
4. Do you cry when you remember bad things from the past?					
5. Are you avoiding activities that remind you of bad things from the past?					
6. Are you avoiding thoughts or feelings associated with bad things from the past?					
7. Are you nervous or scared?					
8. Are you conscious?					
Anxiety & Depression					
9. Do you have trouble in your heart?					
10. Do you have restless nights?					
11. Do you feel lonely?					
12. Do you find life difficult even if you are home or elsewhere?					
13. Are you afraid of losing your family?					
14. Do you feel helpless?					
15. Do you vex quick?					
16. Do you cry easily?					
17. Do you keep to yourself when you are worried?					
18. Are you easily bothered by things?					
19. Do you feel confused about things that are happening?					
20. Do you feel unloved?					
21. Do you feel hopeless about the future?					
22. Do you think about hurting yourself or killing yourself? *					
23. Do you worry about too many things?					
24. Do you think that everything you do is wrong?					
Hostility					
25. Do you destroy things that belong to others?					
26. Do you lie or cheat?					

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Clinical Care Assessment Tool – Client Version

	Not applicable	Not at all	Rarely	Sometimes	Always
27. Do you curse or use abusive language?					
28. Do you think about or threaten to hurt others? *					
29. Do you destroy your own things?					
30. Do you blame others for things that are your fault?					
31. Are you quarrelsome?					
32. Do you take people's things without permission?					
33. Do you disobey your parents or caregivers?					
34. Do you disobey your teachers or other adults?					
Prosocial Behavior					
35. Do you feel confident to invite others to play with you?					
36. Are you ready to work or play with others?					
37. Do you enjoy doing things and talking with your peers?					
38. Do you play games, sports, or dance with friends?					
39. Do you take the lead in initiating activities?					
40. Do you share with others?					
41. Are you actively involved in any club or group activities?					
42. Do you enjoy telling stories with family and friends in the evenings?					
43. Do other children like to associate freely with you?					
44. Do you enjoy collecting firewood (or other community activities)?					
45. Do you go with other children for swimming (or other fun activities)?					
46. Do you want others to respect you?					
47. Do you have love for your peers?					
48. Do you help younger ones?					
49. Do you pity others?					
50. Do you take part in community farming?					
51. Do you share your feelings or ideas with others?					
52. Are you helpful to adults?					
53. Do you like to sit around the fire at night?					
Confidence					
54. Do you have confidence to be responsible for others?					
55. Do you have confidence about your future?					
56. Do you think you can do things like others?					
57. Are you confident of doing things on your own?					
58. Are you satisfied with yourself?					
59. Do you feel safe when you are on your own?					

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Clinical Care Assessment Tool – Client Version

	Not applicable	Not at all	Rarely	Sometimes	Always
Spirituality					
60. Do you find strength and comfort in your religion?					
61. Do you engage in religious practices (pray, attend worship services, etc.) to help you cope with bad things?					
62. Do you believe that God loves you and cares for you, even when bad things happen?					

Trauma Scale, Anxiety & Depression Scale, and Hostility Scale: Items marked with "sometimes" or "always" are clinically relevant, indicating the need for intervention.

Prosocial Behavior Scale, Confidence Scale, and Spirituality Scale: Items marked with "not at all" or "rarely" are clinically relevant, indicating the need for intervention.

* If client answers Question 22 or 28 with "rarely," "sometimes," or "always," counselor must further assess the client for suicidality or harm to others after completing this assessment tool.

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Clinical Care Assessment Tool – Clinician Version

Client #: _____

Date of Administration: _____

Counselor Name: _____

Counselors: Please read each item carefully and determine the severity of each risk factor based on your current observations of the survivor at the shelter. Mark your *answer with an X* according to how problematic each risk factor is for the survivor (One X per question). If you don't know an answer, try to assess the situation more thoroughly before you answer the item.

	Not applicable	Not at all a problem	Minor Problem	Moderate Problem	Serious Problem
Physical Health					
1. Survivor is physically disabled or has current health problems					
2. Survivor is unable to use self-care skills and has poor hygiene					
Educational/Vocational Functioning					
3. Survivor does not appropriately participate in educational classes					
4. Survivor is unable to make appropriate academic progress					
5. Survivor does not appropriately participate in vocational classes					
6. Survivor is unable to adequately use vocational skills due to a disability					
7. Survivor is unable to adequately use vocational skills due to a lack of understanding of the skills that have been taught					
8. Survivor shows poor attention and concentration					
9. Survivor struggles with learning and applying information					
10. Survivor has no interest in educational or vocational training					
Coping Skills					
11. Survivor is unable to use healthy coping skills to deal with her emotions or psychological problems					
12. Survivor engages in self-harming behaviors or thinks about hurting/killing herself					
13. Survivor is unable to resolve conflicts in an appropriate manner					
14. Survivor does not appropriately seek attention, love, and support from caregivers or peers					
15. Survivor believes she is to blame for past traumatic events					
16. Survivor believes she is possessed by demonic forces					
17. Survivor believes that God has abandoned her or is punishing her					
Self-Protection Skills					
18. Survivor trusts adults non-selectively					

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Clinical Care Assessment Tool – Clinician Version

	Not applicable	Not at all a problem	Minor Problem	Moderate Problem	Serious Problem
19. Survivor does not know how to recognize dangerous situations					
20. Survivor is unable to communicate her desires					
21. Survivor is unable to advocate for her needs					
22. Survivor believes she is responsible for fulfilling the financial needs of her family					
23. Survivors wants to (or does) maintain a relationship with the perpetrator					

Physical Health Scale, Educational/Vocational Functioning Scale, Coping Skills Scale, and Self-Protection Skills Scale: Items marked with "moderate problem" or "serious problem" are clinically relevant, indicating the need for intervention.

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ANNEX 9: POST-REINTEGRATION ASSESSMENT TOOL

Post-Reintegration Assessment Tool – Client Version

Client #: _____

Date of Administration: _____

Counselor Name: _____

Counselors: Please read each question carefully to the survivor and ask her how much she currently experiences each symptom. Mark her ***answer with an X*** according to how much she experiences each symptom (One X per question). If she does not know an answer, explain the meaning of the question to her and then re-ask her how much she experiences that symptom.

	Not applicable	Not at all	Rarely	Sometimes	Always
Trauma					
1. Do you think a lot about bad things from the past?					
2. Do you feel as though the bad things that happened in the past will happen again?					
3. Do you have bad dreams?					
4. Do you cry when you remember bad things from the past?					
5. Are you avoiding activities that remind you of bad things from the past?					
6. Are you avoiding thoughts or feelings associated with bad things from the past?					
7. Are you nervous or scared?					
8. Are you conscious?					
Anxiety & Depression					
9. Do you have trouble in your heart?					
10. Do you have restless nights?					
11. Do you feel lonely?					
12. Do you find life difficult even if you are home or elsewhere?					
13. Are you afraid of losing your family?					
14. Do you feel helpless?					
15. Do you vex quick?					
16. Do you cry easily?					
17. Do you keep to yourself when you are worried?					
18. Are you easily bothered by things?					
19. Do you feel confused about things that are happening?					
20. Do you feel unloved?					
21. Do you feel hopeless about the future?					
22. Do you think about hurting yourself or killing yourself? *					
23. Do you worry about too many things?					
24. Do you think that everything you do is wrong?					
Hostility					
25. Do you destroy things that belong to others?					
26. Do you lie or cheat?					

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Post-Reintegration Assessment Tool – Client Version

	Not applicable	Not at all	Rarely	Sometimes	Always
27. Do you curse or use abusive language?					
28. Do you think about or threaten to hurt others? *					
29. Do you destroy your own things?					
30. Do you blame others for things that are your fault?					
31. Are you quarrelsome?					
32. Do you take people's things without permission?					
33. Do you disobey your parents or caregivers?					
34. Do you disobey your teachers or other adults?					
Prosocial Behavior					
35. Do you feel confident to invite others to play with you?					
36. Are you ready to work or play with others?					
37. Do you enjoy doing things and talking with your peers?					
38. Do you play games, sports, or dance with friends?					
39. Do you take the lead in initiating activities?					
40. Do you share with others?					
41. Are you actively involved in any club or group activities?					
42. Do you enjoy telling stories with family and friends in the evenings?					
43. Do other children like to associate freely with you?					
44. Do you enjoy collecting firewood (or other community activities)?					
45. Do you go with other children for swimming (or other fun activities)?					
46. Do you want others to respect you?					
47. Do you have love for your peers?					
48. Do you help younger ones?					
49. Do you pity others?					
50. Do you take part in community farming?					
51. Do you share your feelings or ideas with others?					
52. Are you helpful to adults?					
53. Do you like to sit around the fire at night?					
Confidence					
54. Do you have confidence to be responsible for others?					
55. Do you have confidence about your future?					
56. Do you think you can do things like others?					
57. Are you confident of doing things on your own?					
58. Are you satisfied with yourself?					

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Post-Reintegration Assessment Tool – Client Version

	Not applicable	Not at all	Rarely	Sometimes	Always
59. Do you feel safe when you are on your own?					
Spirituality					
60. Do you find strength and comfort in your religion?					
61. Do you engage in religious practices (pray, attend worship services, etc.) to help you cope with bad things?					
62. Do you believe that God loves you and cares for you, even when bad things happen?					
Family Acceptance & Support					
63. Since leaving the shelter, do you feel you are welcome in the family with whom you live?					
64. Since leaving the shelter, have your caregivers been good to you?					
65. Since leaving the shelter, have you been safe from being verbally, physically, and/or sexually abused by family members?					
66. Do you currently have the same opportunities and responsibilities as other children in the family (or household)?					
67. Since leaving the shelter, do your caregivers adequately support you and help meet your physical needs (food, accommodation, clothing, education, finances)?					
68. Since leaving the shelter, do your caregivers adequately support you and help meet your social and emotional needs?					
Community Acceptance					
69. Since leaving the shelter, do you feel you have been welcomed back into the community where you live?					
70. Since leaving the shelter, have the people in this community been good to you?					
71. Since leaving the shelter, have you been safe from being verbally, physically, and/or sexually abused by community members?					
72. Do community members currently treat you the same way as other children in the community?					
73. Do you regularly interact with friends in your community?					
74. Do you regularly interact with trusted adults in your community?					

Trauma Scale, Anxiety & Depression Scale, and Hostility Scale: Items marked with "sometimes" or "always" are clinically relevant, indicating the need for intervention or monitoring.

Prosocial Behavior Scale, Confidence Scale, Spirituality Scale, Family Acceptance & Support Scale, and Community Acceptance Scale: Items marked with "not at all" or "rarely" are clinically relevant, indicating the need for intervention or monitoring.

* If client answers Question 22 or 28 with "rarely," "sometimes," or "always," counselor must further assess the client for suicidality or harm to others after completing this assessment tool.

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Post-Reintegration Assessment Tool – Clinician Version

Client #: _____

Date of Administration: _____

Counselor Name: _____

Social Worker Name: _____

Counselors and Social Workers: Please read each item carefully and determine the severity of each risk factor based on your current observations and interviews during the follow-up visit. Mark your ***answer with an X*** according to how problematic each risk factor is for the survivor (One X per question). If you don't know an answer, try to assess the situation more thoroughly before you answer the item.

	Not applicable	Not at all a problem	Minor Problem	Moderate Problem	Serious Problem
Physical Health					
1. Survivor is physically disabled or has current health problems					
2. Survivor is unable to use self-care skills and has poor hygiene					
Educational/Vocational Functioning					
3. Survivor is not currently attending school (if school age)					
4. Survivor does not appropriately participate in educational classes					
5. Survivor is unable to make appropriate academic progress					
6. Survivor does not appropriately participate in vocational classes or income generating activities					
7. After attending vocational training, survivor is unable to adequately use vocational skills					
8. Survivor shows poor attention and concentration					
9. Survivor struggles with learning and applying information					
10. Survivor has no interest in educational or vocational training or participating in income generating activities					
Coping Skills					
11. Survivor is unable to use healthy coping skills to deal with her emotions or psychological problems					
12. Survivor engages in self-harming behaviors or thinks about hurting/killing herself					
13. Survivor is unable to resolve conflicts in an appropriate manner					
14. Survivor does not appropriately seek attention, love, and support from caregivers or peers					
15. Survivor believes she is to blame for past traumatic events					
16. Survivor believes she is possessed by demonic forces					
17. Survivor believes that God has abandoned her or is punishing her					

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Post-Reintegration Assessment Tool – Clinician Version

	Not applicable	Not at all a problem	Minor Problem	Moderate Problem	Serious Problem
Self-Protection Skills					
18. Survivor trusts adults non-selectively					
19. Survivor does not know how to recognize dangerous situations					
20. Survivor is unable to communicate her desires or advocate for her needs					
21. Survivor believes she is responsible for fulfilling the financial needs of her family					
22. Survivor wants to (or does) maintain a relationship with the perpetrator					
Family Risk Factors					
23. The caregiver is unable to adequately meet the emotional and social needs of the survivor					
24. The caregiver is unable to adequately meet the physical needs of the survivor (food, accommodation, clothing, education, finances)					
25. The caregiver assigns chores or tasks that are harmful to the survivor's development					
26. The caregiver blames or stigmatizes the survivor					
27. There is (or suspected to be) current family violence, abuse, or caregiver marital problems within the home the family is living in					
28. The caregiver is unable to protect the survivor from high risk situations					
29. Family members have victimized, abused, or exploited the survivor since reintegration					
Community Risk Factors					
30. People in the community currently blame or stigmatize the survivor or her family					
31. The community is not a safe environment for the survivor or her family					
32. Local authorities (village head, police, etc.), school director, and teachers are not supportive or do not understand the needs of the survivor and her family					
33. People in the community are unable to protect the survivor from high risk situations.					
34. Non-family members have victimized, abused, or exploited the survivor since reintegration					

Physical Health Scale, Educational/Vocational Functioning Scale, Coping Skills Scale, Self-Protection Skills Scale, Family Risk Factors Scale, and Community Risk Factors Scale: Items marked with "moderate problem" or "serious problem" are clinically relevant, indicating the need for intervention or monitoring.

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ANNEX 10: INFORMED CONSENT FORM – SEMI-STRUCTURED INTERVIEWS

Informed Consent Form
Roberts Wesleyan College

Program Evaluation of World Hope International's
Trafficking in Persons - Recovery Centre in Sierra Leone

Investigator: Keri Bassett, Ph.D., Associate Professor of Psychology at Roberts Wesleyan College.

Purpose of Study:
This program evaluation is measuring implementation outputs and the expected outcomes of the Trafficking in Persons – Recovery Centre (TIP-RC) project. In particular, this evaluation will study how cooperation with partner organizations, the utilization of referral mechanisms, and the provision of reintegration services contribute to the program model. Also, this evaluation will assess how effective this project has been in building staff capacity, achieving the stabilization and recovery of victims of trafficking, and successfully reintegrating trafficking survivors in the Sierra Leone community.

Procedures:
During this evaluation project, the investigator will conduct semi-structured interviews. Interview questions will ask about your perception of the policies and practices of the TIP-RC in assisting victims of trafficking as well as information about your organization's role in combatting human trafficking in Sierra Leone. Due to the nature of semi-structured interviews, the investigator has a set of questions designed to help you relate your perspectives; however, over the course of the interview, additional clarifying questions may be asked. Throughout the interview process, the investigator will be taking notes of your answers, which will remain confidential. In addition, the data collected from these interviews will **not** be used for employee performance reviews or other employment-related issues.

Voluntary Nature:
Your participation in this evaluation is completely voluntary and you may withdraw your consent to participate at any time during the process without penalty. You also may refuse to answer questions without penalty. If you choose to do so, any information derived from your participation will be deleted from the evaluation's findings.

Risks and Benefits to Participant:
There are no known risks associated with this evaluation project. If you feel uncomfortable with some of the questions in the interview, you can stop at any time. A potential benefit of participating in this evaluation project is that the findings may help with improving the quality of care provided at the TIP-RC. Additionally, the findings from this project have the potential to benefit society by providing a clearer understanding of factors contributing to effective aftercare services for victims of trafficking.

Compensation:
There is no compensation in this evaluation project.

Confidentiality:
Your participation in this evaluation project will be strictly confidential. No identifying information will be collected in this project, and all findings will be reported in aggregate form with no identifying information. However, direct quotes may be used in written reports or publications to more clearly capture the meaning of the findings. No identifying information will be attached to direct quotes. At the end of your interview, you will be asked if there is anything you said that you do not want included as a quote, and the investigator will ensure that these statements are not used.

The data from this evaluation project will be stored in a locked cabinet or a password protected computer in the investigator's office. Only Dr. Keri Bassett will be able to access the data. The results obtained from this study may be used for writing reports, scientific journals, or presented at scientific meetings.

Contacts and Questions:
If you have any questions about this study or you experience any discomfort at any time, you may contact Dr. Keri Bassett at Roberts Wesleyan College, 2301 Westside Drive, Rochester, NY 14624, 585-594-6943, bassett_keri@roberts.edu. You may also contact Dr. Rodney Bassett, Chair of the Institutional Review Board at Roberts Wesleyan College. You may email him at Bassettr@roberts.edu or call 585-594-6680.

DOCUMENTATION OF INFORMED CONSENT

You are voluntarily making a decision whether you wish to participate in this research project. Your signature certifies that you have decided to participate having read and understood the information presented. You will be given a copy of this consent form to keep.

Participant Name (Print) _____

Participant Signature _____

Date _____

ANNEX 11: INFORMED CONSENT FORM – DIRECT OBSERVATIONS

Informed Consent Form
Roberts Wesleyan College

Program Evaluation of World Hope International's
Trafficking in Persons - Recovery Centre in Sierra Leone

Investigator: Keri Bassett, Ph.D., Associate Professor of Psychology at Roberts Wesleyan College.

Purpose of Study:
This program evaluation is measuring implementation outputs and the expected outcomes of the Trafficking in Persons – Recovery Centre (TIP-RC) project. In particular, this evaluation will study how cooperation with partner organizations, the utilization of referral mechanisms, and the provision of reintegration services contribute to the program model. Also, this evaluation will assess how effective this project has been in building staff capacity, achieving the stabilization and recovery of victims of trafficking, and successfully reintegrating trafficking survivors in the Sierra Leone community.

Procedures:
Over the course of your normal job responsibilities, direct observations will be used to assess general patterns of interaction and functioning of the TIP-RC staff members. The focus of the observations will be on general patterns of the entire staff, not on individual employees or clients. The data collected from these observations will **not** be used for employee performance reviews or other employment-related issues.

Voluntary Nature:
World Hope International values the potential benefits that this evaluation project may provide to the organization and to the quality of care provided to the TIP-RC's clients. Therefore, participation in the direct observations of staff members' normal job responsibilities is not voluntary.

Risks and Benefits to Participant:
There are no known risks associated with this evaluation project because participants will only be observed in completing their normal job responsibilities. A potential benefit of participating in this evaluation project is that the findings may help with improving the quality of care provided at the TIP-RC. Additionally, the findings from this project have the potential to benefit society by providing a clearer understanding of factors contributing to effective aftercare services for victims of trafficking.

Compensation:
There is no compensation in this evaluation project.

Confidentiality:
Your participation in this evaluation project will be strictly confidential. No identifying information will be collected in this project, and all findings will be reported in aggregate form with no identifying information. The data from this evaluation project will be stored in a locked cabinet or a password protected computer in the investigator's office. Only Dr. Keri Bassett will be able to access the data. The

results obtained from this study may be used for writing reports, scientific journals, or presented at scientific meetings.

Contacts and Questions:
If you have any questions about this study or you experience any discomfort at any time, you may contact Dr. Keri Bassett at Roberts Wesleyan College, 2301 Westside Drive, Rochester, NY 14624, 585-594-6943, bassett_keri@roberts.edu. You may also contact Dr. Rodney Bassett, Chair of the Institutional Review Board at Roberts Wesleyan College. You may email him at Bassettr@roberts.edu or call 585-594-6680.

DOCUMENTATION OF INFORMED CONSENT

You are voluntarily making a decision whether you wish to participate in this research project. Your signature certifies that you have decided to participate having read and understood the information presented. You will be given a copy of this consent form to keep.

Participant Name (Print) _____

Participant Signature _____

Date _____

ANNEX 12: LOGIC MODEL OF THE TIP-RC PROJECT

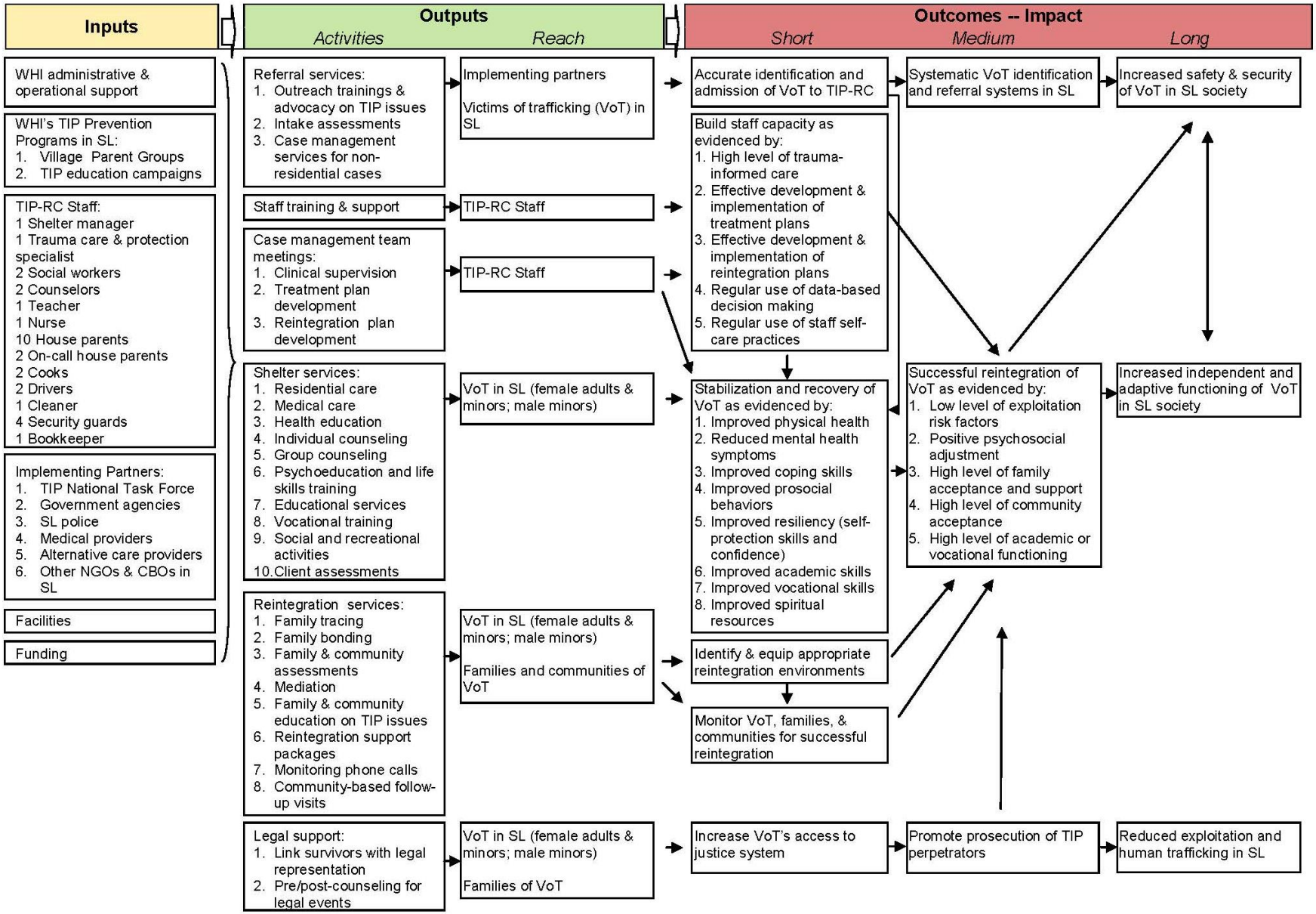
Logic Model for World Hope International's Trafficking in Persons – Recovery Centre (TIP-RC)

Assumptions

- Program design is based on a victim-centered approach and follows international standards for TIP aftercare, but is contextualized for the SL context.
- Comprehensive care requires a partnership with social services, community stakeholders, police, and government sectors.
- Long-term residential care is not optimal for child development, especially in a family-oriented society like SL.
- Clinical treatment model emphasizes the importance of therapeutic relationships in the recovery process.
- Decision making is based on the best interest of the VoT.
- Team-based decision making improves quality of care.

External Factors

- Limited structure, resources, or capacity in the GOSL to combat human trafficking.
- Prosecution of human trafficking perpetrators is very low in SL due to problematic systemic issues in the judiciary.
- Severely inadequate educational, medical, mental health, and social services in SL. Most available services are located in Freetown, but there is a lack of efficient and affordable transportation in SL.
- Due to the low education levels and the lack of training in human services in SL, there is an extremely limited pool of qualified service providers, especially in regards to female service providers.
- Building staff capacity in SL requires a significant amount of modeling, hands-on practice, and supervision in addition to the provision of content knowledge.
- The cultural practice of mend pikin (i.e., children being fostered out and raised by someone other than their biological parents) can mask exploitation and contribute to the use of deception during trafficking acts.
- Cultural beliefs related to human trafficking issues, especially in regards to sexual exploitation and mental health symptoms, can lead to the stigmatization of VoT, increasing the risk of re-trafficking or additional exploitation.
- WHI had a strong record of anti-trafficking work in SL and developed strong working relationships with service providers, police, and SLG before starting the TIP-RC.


Inputs
Outputs
Activities
Reach
Outcomes -- Impact
Short
Medium
Long
WHI administrative & operational support
WHI's TIP Prevention Programs in SL:
1. Village Parent Groups
2. TIP education campaigns
TIP-RC Staff:
1 Shelter manager
1 Trauma care & protection specialist
2 Social workers
2 Counselors
1 Teacher
1 Nurse
10 House parents
2 On-call house parents
2 Cooks
2 Drivers
1 Cleaner
4 Security guards
1 Bookkeeper
Implementing Partners:
1. TIP National Task Force
2. Government agencies
3. SL police
4. Medical providers
5. Alternative care providers
6. Other NGOs & CBOs in SL
Facilities
Funding
Referral services:
1. Outreach trainings & advocacy on TIP issues
2. Intake assessments
3. Case management services for non-residential cases
Implementing partners
Victims of trafficking (VoT) in SL
Accurate identification and admission of VoT to TIP-RC
Systematic VoT identification and referral systems in SL
Increased safety & security of VoT in SL society
Staff training & support
TIP-RC Staff
Case management team meetings:
1. Clinical supervision
2. Treatment plan development
3. Reintegration plan development
TIP-RC Staff
Build staff capacity as evidenced by:
1. High level of trauma-informed care
2. Effective development & implementation of treatment plans
3. Effective development & implementation of reintegration plans
4. Regular use of data-based decision making
5. Regular use of staff self-care practices
Shelter services:
1. Residential care
2. Medical care
3. Health education
4. Individual counseling
5. Group counseling
6. Psychoeducation and life skills training
7. Educational services
8. Vocational training
9. Social and recreational activities
10. Client assessments
VoT in SL (female adults & minors; male minors)
Stabilization and recovery of VoT as evidenced by:
1. Improved physical health
2. Reduced mental health symptoms
3. Improved coping skills
4. Improved prosocial behaviors
5. Improved resiliency (self-protection skills and confidence)
6. Improved academic skills
7. Improved vocational skills
8. Improved spiritual resources
Successful reintegration of VoT as evidenced by:
1. Low level of exploitation risk factors
2. Positive psychosocial adjustment
3. High level of family acceptance and support
4. High level of community acceptance
5. High level of academic or vocational functioning
Increased independent and adaptive functioning of VoT in SL society
Reintegration services:
1. Family tracing
2. Family bonding
3. Family & community assessments
4. Mediation
5. Family & community education on TIP issues
6. Reintegration support packages
7. Monitoring phone calls
8. Community-based follow-up visits
VoT in SL (female adults & minors; male minors)
Families and communities of VoT
Identify & equip appropriate reintegration environments
Monitor VoT, families, & communities for successful reintegration
Legal support:
1. Link survivors with legal representation
2. Pre/post-counseling for legal events
VoT in SL (female adults & minors; male minors)
Families of VoT
Increase VoT's access to justice system
Promote prosecution of TIP perpetrators
Reduced exploitation and human trafficking in SL